St Philips Care Limited

Bowburn Care Centre

Inspection report

Bowburn South Industrial Estate
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Date of inspection visit:
28 January 2021
01 February 2021
02 February 2021
03 February 2021
04 February 2021
08 February 2021
09 February 2021

Date of publication:
12 March 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Bowburn Care Centre is a residential care home providing accommodation with personal care to older people, some of whom were living with dementia. The service can support up to 80 people in one building over two floors. At the time of this inspection, 65 people lived at the service.

People's experience of using this service and what we found
We arrived at the home at 6am and found a large number of people were already up and dressed by night staff. We raised with the interim manager that people were dozing and why were so many people up and dressed at this time.

Staffing levels were not always safe. Records relating to peoples' health and wellbeing such as weight and fluid charts were not always documented. This meant that people were at risk of not receiving safe care. Accidents and incidents had not been thoroughly recorded and action to follow up on them had not always been taken.

Medicines had not been managed safely. Staff had not received appropriate training and competency assessments. Guidance from other professionals had not always been put in place promptly. Medicines ordering was poor with large overstocks and records relating to medicines management were poor or not in place.

The service did not have sufficient infection prevention and control measures in place. Government guidance in relation to COVID-19 was not always followed. Staff were not all wearing appropriate Personal Protective Equipment (PPE). Cleaning programmes were not recorded so it could not be evidenced if these had taken place. Safety equipment such as sensor checks and mattress checks had not been carried out.

Quality assurance processes to monitor the quality and safety of the service had not been carried out. There was a lack of provider oversight and they had not ensured effective and competent management was in place.

All staff members we spoke with raised concerns about the management of the service. Staff we spoke with said they felt unsupported by the registered manager and at times unsafe. Staff told us they were happy about the interim manager and felt they were now listened to.

We did observe people appeared comfortable and happy with staff interaction with them. Since our inspection the new interim manager and provider had carried out robust audits, brought in additional staff and were providing regular updates on an action plan to address the issues we found.

For more details, please see the full report which is on the Care Quality Commission website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (report published 22 October 2020)

Why we inspected
Serious whistleblowing concerns were received by the local authority safeguarding team in relation to management of the service and the quality of care and support that was being provided. There had been a number of safeguarding concerns raised by other professionals. As a result, we carried out a focused inspection to review the key questions of safe, responsive and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make substantial improvements. Please see the safe, responsive and well-led sections of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the safety of people and the risk of harm. We also identified breaches in relation to the management and monitoring of the service, person-centred care and staffing at this inspection.

Please see the action we have told the provider to take at the end of this 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.

Follow up
We will continue to monitor information we receive about the service and we will continue to work with partner agencies. We will also request a specific action plan to understand what the provider will do immediately to ensure the service is safe. We will work alongside the provider and the local authority to closely monitor the service. We will return to visit in line with our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Bowburn Care 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 Care Act 2014.

Inspection team
The inspection team consisted of two inspectors, one undertook the site visit and another undertook telephone calls with staff.

Service and service type
Bowburn Care Centre is a 'care home'. People in care homes receive accommodation and nursing or 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.

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. The registered manager was absent from the service at the time of our inspection visit and an interim manager had been in post for a short time.

Notice of inspection
We carried out this inspection unannounced.

What we did before the inspection
We spoke with the local safeguarding team following whistleblowing concerns that were raised about the service.

We reviewed information we had received about the service since the last inspection. We spoke with local safeguarding authority team members and service commissioners. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with four people, the interim manager, regional manager, regional support manager, three senior care workers, and six care staff members both on inspection and after the inspection during telephone interviews.

We reviewed five care plans, five Medicine Administration Records (MARS), two staff files and a variety of records relating to the quality of the service.

After the inspection
We requested further information from the interim manager, regional manager and nominated individual for the provider.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Infection control

- People were not protected from the risk of infection.
- The provider had failed to implement and follow COVID-19 guidance to reduce the risk of infection. For example, staff were not following basic hand hygiene procedures, we observed an open bag of clinical waste on the floor and social distancing was not being followed.
- Cleaning records were not in place to confirm if cleaning routines were being adhered to.

Staffing and recruitment

- Staffing was not provided at safe levels.
- Staff told us they had worked without enough staff to always deliver safe care. We saw staffing had not been provided to the provider's assessed dependency levels.
- Staff recruitment had not been undertaken in line with the provider's policy so references and gaps in employment history had not always been checked.

The provider failed to ensure suitably qualified, competent, skilled and experienced staff were deployed at the service to meet the needs of people using the service and keep them safe at all times. This is a breach of Regulation 18, (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider responded immediately during and after the inspection. They confirmed that agency staff had been brought in to the service so that staffing was being provided at their dependency assessment levels.

Systems and processes to safeguard people from the risk of abuse

- The provider did not always keep people safe from the risk of abuse. Staff members concerns about alleged abuse had not always been fully investigated or alerted to the local authority safeguarding team. Staff told us about some of these concerns when we inspected the service and we shared these with the local safeguarding service.
- The provider had policies and procedures to deal with allegations of abuse but staff we spoke with told us the registered manager did not listen to them.
- Staff were not encouraged to speak up and raise issues or concerns.

This was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines had not been administered safely.

● Staff with the required medication training were not always on duty. This had resulted in staff, who had not received appropriate training or had their competencies assessed, were administering medication.
● Instructions provided by other professionals with regard to medicines had not been followed. For example, staff did not understand the implications and process that needed to be undertaken to administer medicines covertly.
● We witnessed staff administering medicines without using any safe infection control procedures. They did not wear appropriate PPE.

The provider failed ensure the proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider responded immediately during and after the inspection by immediately ensuring staff received training and had their competency assessed.

Assessing risk, safety monitoring and management
● Risks to people had not been appropriately assessed or managed.
● People's records relating to weight maintenance, pressure area care and food and fluid recording were poor.
● Where people had a daily fluid target to be reached each day because they were at risk of dehydration, where this was not achieved, there was no evidence to demonstrate how this was being monitored and addressed to ensure people's safety and wellbeing.

The provider failed to assess the risks to the health and safety of people and do all that is reasonably practicable to mitigate any risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Systems and processes were not in place to ensure lessons could be learnt when things went wrong.
● Accidents and incidents had not been fully recorded or investigated by management and there were delays in reporting accidents and safeguarding incidents to the appropriate authorities.

The provider failed to assess the risks to the health and safety of people and do all that is reasonably practicable to mitigate any risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider responded immediately during and after the inspection by ensuring accident and incidents were reviewed and providing training for all staff.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this rated has deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People were at risk of not receiving care that met their needs.
- We did not observe that people's wishes were always upheld. We witnessed a large number of people already up and dressed at 6am in the morning, many of whom where dozing in chairs. We could not ascertain whether this was their choice but appeared to be poor staff practice.
- People did not have regular weights recorded or information about wound care. We saw regular observations required such as food and fluid charts, blood sugar levels and wound care were not completed.
- Care plans, daily records and risk assessments only contained basic information which meant people's views and preferences about how they wanted their care to be given were not always taken into consideration. For example, for one person it stated their preference was to have a bath. Throughout January 2021, they had been offered one bath and three showers. We saw for a period of five days there was no recorded support to provide personal care to this person.

This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff appeared to know people well and engaged positively with people.

End of life care and support

- The circumstances we found during the inspection relating to staffing levels and poor infection control practices were not conducive to good quality end of life care.
- Advanced care planning, emergency care and resuscitation preferences were recorded.

This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Staff reported to us that activities were not happening regularly due to staffing shortages and activity staff providing care and support.

Inadequate

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager did not understand quality performance, risk and regulatory requirements.
- Quality assurance processes were in place but had not been carried out for the last three months. The lack of systems and processes in place to identify concerns or shortfalls within the service placed people at increased risk. For example, failure to train staff in medicines administration and failure to ensure appropriate infection prevention control measures were in place.
- Notifications and safeguarding alerts had not always been submitted in a timely way.
- The provider had also been unable to provide evidence for the inspection that should have been on site or available to them as they were unable to locate these. These were records such as complaint investigations and outcomes.

The provider failed to ensure systems and processes were in place to assess, monitor and improve the service. This was a breach of Regulation 17, (Good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider responded immediately during and after the inspection by submitting notifications that were overdue.

Continuous learning and improving care

- Investigations and auditing of incidents and accidents were not always robust, fully completed or managed appropriately to mitigate future risks to people.

The provider had failed to reduce or remove risks where possible which had a negative impact on people using the service. This was a breach of Regulation 17, (Good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- A person-centred culture was not promoted. Some staff told us they felt unable to raise concerns as they felt they were not listened to.
- Staff did not feel supported within their roles. expressed concerns over the lack of management within the service. They had not been provided with sufficient training to ensure they had the skills and knowledge they needed.
- Staff did feedback they welcomed the interim manager and they were now being listened to and felt

supported. They stated morale, staffing levels and support was improving.

The provider had failed to act on feedback from staff to evaluate and improve the service. This was a breach of Regulation 17, (Good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider responded immediately during and after the inspection by submitting notifications that were overdue.

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 registered manager had not been responsive to issues and concerns. They had failed to be open, honest, and apologise to people when things went wrong.
- The provider failed to report concerns in relation to COVID-19 to the local authority and Public Health England in a timely manner to enable appropriate, additional support to be provided.
- The registered manager had not sought the views of people through the use of feedback surveys.

The provider failed to seek and act on feedback provided or concerns raised. This was a breach of Regulation 17, (Good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The service had not engaged with partners.
- The service had been offered support throughout the COVID-19 pandemic from the CQC, the local authority and infection and prevention control nurses. All partners were led to believe from the registered manager there were no issues with the service understanding and following guidance.
- Professionals who had been visiting the service expressed concerns over the care and support people were receiving.

The provider failed to ensure the care and treatment was appropriate, met people's need and reflected people's preferences. This was a breach of Regulation 9, (person-centred care), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 9 HSCA RA Regulations 2014 Person-centred care We saw people were not being supported to have choice about when they got up and went to bed.