Selborne Care Limited

Selborne Mews

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Selborne Mews is a care home and accommodates up to 20 people with learning disabilities. Some people living at the service were also diagnosed with mental health conditions and had complex support needs.

At the time of our inspection 13 people were living at the service.

People's experience of using this service and what we found
Care and treatment was not always provided in a safe way. There was a lack of provider oversight which meant risks to people's safety had not always been identified and responded to appropriately. Systems to monitor the quality and safety of the service were ineffective and placed people at the risk of harm.

Systems in place to manage the control of infection were not effective and did not always follow current government guidance in relation to COVID19.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. The service was a large home, bigger than most domestic style properties. However the size of the service having a negative impact on people was mitigated in part by people being provided with individual living accommodation. Not all the people had been supported to live inclusive and empowered lives. The service had not supported all people living there to personalise their own living environments and not all people's communication needs were being met effectively.

People received their medicines when needed. Staff knew people's needs and felt supported by the management team. Staff understood what action to take if they suspected somebody was being harmed or abused. Arrangements were in place to ensure staff received the required physical intervention training.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published January 2020) and there was two breaches of the regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the required improvements had not been made. We found that regulation 12 safe care and regulation 17 good governance were not met. There was also a new breach of regulation 18

failure to notify CQC about incidents at the service in a timely way.

Why we inspected
We undertook this focused inspection due to incoming information of concern about incidents that had taken place at the service and we were concerned about people's safety. We also wanted to check if the provider had followed the action plan they sent us to confirm they had met the legal requirements.

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.
The ratings from the previous comprehensive inspection for the key questions of effective and responsive were not looked at on this occasion the ratings from the last inspection were used in calculating the overall rating at this inspection.

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 six 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in a well- led findings below.

Selborne Mews

Detailed findings

Background to this 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.

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.

Inspection team
The inspection was carried out by two inspectors and an assistant inspector.

Service and service type
Selborne Mews 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 who was in the process of registering with the Care Quality Commission.

Notice of inspection
The inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service. We sought feedback from the local authority. We received information of concern about people's safety and that was the trigger for this inspection. We reviewed the information received in the provider information return. 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 used all this information to plan our inspection.

During the inspection

We spoke with eleven staff this included the manager, care staff and the regional manager and nominated individual.The nominated individual is responsible for supervising the management of the service on behalf of the provider. We met six people and observed their care and sought their views.

We reviewed a range of records. This included four people's care records. We looked at two staff files in relation to recruitment. We also looked at a variety of records relating to the management and quality assurance of the service.

After the inspection
We looked at further records and continued to seek clarification from the registered provider to validate evidence found.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection

●At our last inspection we found systems in place to assess and manage risks to people were not always effective. At this inspection we found the required improvements had not been made.

●One person had a health condition which meant they were at risk of eating non-food items (PICA). A risk assessment was in place and stated that specific items in their bedroom (toiletries) should be locked away when not in use. The lock on the cupboard where the items were stored was broken so items were not secured, and no interim measures had been taken to secure the items or inform the manager about the risk. The person was in the room and no staff were present. Staff were aware of the risks and knew the items should be secured. However, when the locking facility broke, prompt action was not taken to mitigate the risk to the person placing them at risk of harm. There was additional risk in their environment including a ripped back of a chair with exposed foam and a container with hand gel, no action had been taken to secure or remove these items either which could be ingested. This placed the person at risk of harm.

●Observational checks on a person's safety were not always completed as recorded in their care plan and also it was not clear how it had been determined that the person with high support needs could be left unsupervised for 45 minute intervals. We shared our concerns with the manager and provider. Five days after our inspection the person was exposed to an incident that placed them at risk of harm. The provider reported the incident to the local authority and the incident was under investigation at the time of writing this report.

●One person had a free- standing electrical heater that was in use in their lounge area. No risk assessment had been completed to assess the potential risks to the person of accidently touching the surface and causing injury. This placed the person at risk of harm.

●GP advice regarding fortifying a person's diet was not followed. Fortifying food involves adding nutrients to help people maintain and improve their health. The person's care records had not been updated to include this information.

●Risk identified in the pre-assessment process were not always implemented to manage the risks. For example, a person was at risk of breaking furniture and using it to self-harm but no assessment of their living environment to identify potential risks had been completed.

●Where risks had been identified through the pre-assessment process and care plans were in place to manage the risk, these were not consistently followed in practice. For example, a person was assessed to be at risk of smoking in their bedroom. The care records said their lighter should be held by staff. However, the person was allowed to hold onto their own lighter. An incident had occurred were the person set alight to bedding in their bedroom.

●There had been an increase in a person's need, and this presented as health and safety risks to the person and other people living at the home. However, a delay in reporting some of the incidents to CQC meant we

were not in a position to ask for reassurance about people's safety or how specific risks were being managed.

●We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. The lack of cleanliness in people's flats placed them at increased risk of cross infection. We looked at three flats. In one flat we saw thick dust and dirt behind the sofa in the lounge area, we saw the sofa had food debris and staining. The shower was heavily soiled with staining on the bath mat. The bedroom chair had food and dirt and was heavily worn making cleaning difficult. A floor bean bag for the service user to lie on was soiled. The carpet was heavily soiled and stained. The pillows in use on the bed was stained and worn. In another flat we saw holes in the wall had been filled with tissue paper and the walls were dirty. This lack of cleanliness placed people at increased risk of infection.

●We were not assured the provider was using PPE effectively and safely. People's individual needs regarding the required level of PPE had not been risk assessed in line with government guidance (Personal protective equipment (PPE) resource for care workers working in care homes during sustained COVID- 19 transmission in England updated 16 April 2021). This meant people were placed at increased risk of infection.

●We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed because the manager had not kept up to date with current guidance.

●We were somewhat assured that the provider's infection prevention and control policy was up to date. However, the manager had not kept up to date with the providers policy and recent changes in government guidance.

Risk's to people's health and welfare were not mitigated. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did take some immediate action on concerns raised. For example, the items were secured when brought to the managers attention. One person was no longer living at the service so the risks in relation to their care were removed.

●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 accessing testing for people using the service and staff.

Staffing and recruitment

●There was some vacant post that were in the process of being appointed to and the manager explained there had been recent changes at team leader level with four new staff in post.

●Most people were supported on a one to one or higher staffing level and the manager told us that minimum staffing levels were being met.

●Staff told us that at times they were short staffed, and staff were moved around to cover for people. Staff told us that the managers were aware, and recruitment was taking place.

●The provider had their own human resource department who carried out checks on staff before they started work in the home to make sure they were suitable to work with people. This included Disclosure and Barring Service (DBS) checks. This is a national service that keeps records of criminal convictions. Completing these checks reduces the risk of unsuitable staff being employed. The home kept a staff record confirming that checks had been completed. Two staff files looked at did not have a record of the start date and one staff record had not recorded that proof of identity had been checked.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

●Prior to our inspection CQC had received information of concern about people's safety and that was the trigger for this inspection.

●On the morning of our inspection an allegation of verbal abuse from a staff member to a person had taken place. The manager had taken the appropriate action and reported the allegation to safeguarding. This was under investigation at the time of writing this report.

●Shortly after our inspection we received whistle blowing concerns regarding safety of a person who was no longer living at the service, safety of staff when supporting people with behaviour that challenges, unsafe staffing levels and cleaning supply shortages. We asked the provider for reassurance on these matters and shared the information with the local authority.

●The local authority advised that eight safeguarding concerns were under investigation at the time of writing this report.

● People who could tell us, told us they felt safe living at the service. One person told us, " I like living here and I feel safe in my flat."

● Staff told us they had received safeguarding training and confirmed their understanding of protecting people from poor care or harm. Staff told us they would report any safeguarding concerns to the manager. A staff member told us, "Yes, I learnt how to report safeguarding issues and who to report them to. It is our job as support workers, it is our responsibility to protect service users." Another staff member told us, "I would report any safeguarding's to my manager and if nothing was done, I would go straight to CQC."

Using medicines safely

●We received some whistle blowing concerns regarding medicine management in November 2020. We shared these concerns with the local authority and the provider at that time. The manager told us they had implemented a new medicine system. They also identified some staff responsible for medicine administration were not following the medicine policy and procedures and they addressed these performance issues through their procedures.

●There was no open date on one medicine that was in use. Medicines should be dated when open, so they are only used for the period they remain effective for.

●Protocols were in place for medicines to be given on an as required basis.

●The people whose medicines we checked had arrangements in place to store their medicines safely.

●Staff competency for safe medicine practice were in place and repeated every six months. If an error was noted in their practice the competencies checks were repeated.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- One person was lying on their bed; the bottom sheet had come away so they were lying on a rubber mattress, against a wall. Staff came into their bedroom, but no attempt was made to check the person or make them comfortable.
- Some staff when entering people's flats did not knock their flat door or announce their arrival. This did not afford the privacy of the person living in the flat.
- In another person's flat we saw positive interaction between the person and the staff supporting them. There was lots of laughter and smiling. The person was laughing and enjoying staff's company. When we spoke with the staff, they knew the person's needs well.
- Staff told us they promoted people's independence and would encourage and support people to do as much as they could for themselves. One person told us, "Staff help me to do the shopping and cooking."

Ensuring people are well treated and supported; respecting equality and diversity

- Staff told us that people's equality and diversity was respected. However, we saw some inconsistencies in how people were being supported and cared for. Staff did not always speak to or acknowledge people with limited verbal communication. We saw that one person who had limited verbal communication had no effective communication system in place. A staff member told us that this was in progress, however the person had lived at the service for a few years. This did not ensure that all people were valued and respected.
- Some of the flats that we visited had not been well maintained or kept clean and had not been personalised for the person. This did not ensure the provider had supported people to feel welcome and comfortable in their surroundings.

Supporting people to express their views and be involved in making decisions about their care

- People told us they were involved with making decisions about their care. One person told us, "I like living here. It's nice, I am getting on well. They went on to tell us, "The staff talk to me and I can choose what I want to do."
- Another person told us that staff spoke with them and asked them about their care, but they had not seen their care plan.
- Staff spoke about the people they cared for in a kind manner. A staff member told us," We get to know the person over time and build up trust and a bond with the person."

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

- At our last inspection we found risks to people were not well managed. The escalation of risk and dissemination of information in relation to risk had not been robust. This was again a concern at this inspection.
- There was a governance system in place, but this had not been operated effectively and had failed to identify the concerns we found during the inspection.
- The system in place to identify potential risks in people's environment and take action to mitigate the risk were not effective and when things went wrong effective contingency plans were not in place. For example, when a lock broke on a cupboard to secure items that were a risk to a person the items were not moved to a secure place and the manager was not informed of the broken lock. They were not aware until we informed them.
- The system in place to oversee and monitor people who required their weight to be monitored (for health reason's) was not effective. Only the month the person was weighed was recorded and no time or date. There was no analysis of weight loss or gain and where the change was significant there was no evidence this had been followed up with health care professionals. Care plans and risk assessments had not been reviewed to show an explanation of changes in people's weight.
- The system in place to ensure that risks to people were assessed, recorded and monitored were not always effective. For example, a person with complex needs was being checked by staff at 45-minute intervals. However, there was no assessment to say how this time frame had been determined, what staff would be checking on. When the checks were not carried out as stated the system in place to check these, failed to identify this.
- The system in place failed to ensure the provider operated a robust pre- admission process. Risk were not always identified or if they were identified, plans in place to manage the risk were not always followed, and this placed people at risk of harm.
- Systems in place for the management of effective infection control had failed to ensure that providers own guidelines or government guidelines were being followed. Cleaning schedules and checks had been put in place and enhanced because of COVID- 19. However, the cleaning schedules were not being followed and the system in place to oversee their effectiveness failed. This meant people were living in environments there were not clean and placed them at risk of infection.
- System in place to ensure people were protected from the risk of COVID- 19 were not effective. The manager was not aware of changes in the providers and government guidance. This meant that individual

risk assessments regarding what PPE should be in place to support people safely, had not been updated. This meant staff were not always wearing the right level of PPE protection. The system in place to oversee this had failed.
●At our last inspection in December 2019 we found breaches of regulation 12 and 17. The provider submitted an action plan and told us that improvements had been made. At this inspection we found the provider had failed to sustain these improvements.

Systems to assess, monitor and improve the quality and safety of the service were not effective. This was a repeated breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●CQC had not been informed in a timely way about legally notifiable incident. This meant CQC were not able to seek reassurance from the provider about people's safety

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2014.

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 manager told us they understood their responsibility to be open and honest when things go wrong. They told us there had been no complaints or concerns made directly to the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●There was mixed feedback from staff. Some staff felt they worked well as a team, some staff felt things were different depending on which team of staff were on shift. A staff member told us, "There is a different atmosphere in the home depending on which team are working."
●Staff told us there had been lots of management changes and they felt supported by the current management team. A staff member told us, "If something needs doing the manager or deputy will get it done, we just need more staff."
●Staff told us they were asked to contribute to the day to day running of the home and felt involved in people's care. A staff member told us, "We have regular staff meetings and discuss things." Another staff member told us, "We are involved in people's care, for example it was [person's name] birthday and I was involved and asked about presents they may like."
●Staff were helpful, and we saw some kind and caring interactions with people. One person told us, "The staff are nice I get on well with them."

Working in partnership with others;
●The service worked in partnership with other professionals and agencies, such as health care professionals and social workers.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Arrangements in place did not ensure people were safe.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Arrangements in place did not ensure effective oversight of the service.

The enforcement action we took:

NOP