Vesta Care (UK) Limited

Paul Murphy Centre

Inspection report

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25 May 2023
27 May 2023

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Paul Murphy Centre is a residential care home providing personal care for up to 8 people with a learning disability and / or autism. At the time of our inspection, 5 people were living at the Paul Murphy Centre. There was no one accessing the respite service on the day of our inspection however some people were accessing this element of the service over the weekend.

People's experience of using this service and what we found

Right Support: Medicines were received, stored, and disposed of safely. However, staff involved in handling medicines did not always follow the home's own policies for medicines record keeping and administration. This meant that we could not be assured that medicines were given safely as prescribed.

Support that was provided was person centred.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Right Care: People received kind and person-centred care. Staff responded to individuals needs well and supported them in a person centred manner. The service worked well with external health care professionals where needed.

Right Culture: People received good quality care from the service and the service knew individuals well and responded well to their needs. Individuals were involved in the service delivery and also planning of their care. The service engaged those who lived and worked at the service and acted on feedback. Feedback from relatives was very positive.

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 27 March 2021)

At this inspection we found the provider to be in breach of one regulation. The service remains rated requires improvement.

Why we inspected

We carried out an announced/ unannounced comprehensive inspection of this service on 27 March 2021. A breach of legal requirements were found. The provider completed an action plan after the last inspection to

show what they would do and by when to improve.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service remains requires improvement. This is based on the findings at this inspection.

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

Enforcement and Recommendations

We have identified a breach in relation to safe use of medicines at this inspection. We also made a recommendation regarding the providers governance systems.

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

Follow up

We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Paul Murphy 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 Health and Social Care Act 2008.

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 conducted by 1 inspector, 1 medicines inspector and 1 Expert by Experience (ExE). 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
The Paul Murphy Centre 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.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 25 May 2023 and ended on 6 June 2023. We visited the location's service on 25 May 2023 and 27 May 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who worked with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We observed staff interacting with people who used the service and spoke with 5 relatives about their experience of the care provided. We spoke with 6 members of staff including the business manager (who is also the nominated individual), registered manager, new incoming manager and two senior support workers and one support worker. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included individual care records and 4 medicine administration records. We spoke with staff and looked at the governance arrangements for the safe handling of medicines. We looked at 3 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures and audits were reviewed.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● Staff did not always follow the home's policy for medicines record keeping and administration. For example, medicines administration records were not always dated, and we observed that they were not completed at the time of administration to each person. Clear, accurate records of medicines received into the home were not consistently made. This meant that we could not be assured that medicines were given safely as prescribed.

● Additionally, on occasions old paperwork had not been removed from individual medicines files, increasing the risk of mistakes. We saw one example where confirmation of changes to the medicines brought into the service with a respite service user had not been sought. the provider took prompt action to address this after the inspection.

This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's medicines needs were assessed on admission to the home. For people living at the home, the visiting primary care team supported medicines reviews. Staff had completed a range of medicines related training to meet the needs of people.

● Staff made sure people received information about medicines in a way they could understand although on occasion, easy read information was not fully personalised. Individual guidance was in place for managing people's 'when required' medicines, to help ensure these medicines were used correctly. Appropriate arrangements were in place to support people with their medicines when away from the home.

Systems and processes to safeguard people from the risk of abuse

● Systems were effective at safeguarding people from the risk of abuse.

● Safeguarding training was up to date for staff. The provider had appropriate safeguarding and whistle blowing policies in place

● The service submitted required notifications and referrals where required.

Assessing risk, safety monitoring and management

● The provider completed risk assessments that were detailed and reflected individuals' needs.

● The required health and safety checks were completed, including gas safety, legionella, and fire safety.

● The provider effectively monitored the safety of those at the service. The provider had appropriate

equipment in place to meet people needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Staffing and recruitment; learning lessons when things go wrong.
● Recruitment at the service was robust.
● Staffing levels were appropriate to meet the needs of those living at the service. Sufficient staff were visible throughout the inspection.
● Accidents and incidents were reviewed by the management team and actions from this were identified.

Preventing and controlling infection
● We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was using PPE effectively and safely.
● We were assured the provider was responding effectively to risks and signs of infection.
● We were assured the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured the provider's infection prevention and control policy was up to date.

Visiting in care homes
● Visiting at the home was in line with current guidance.

Requires Improvement

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

At the last inspection, the provider did not have a system of robust quality assurance and provider oversight of the services fire safety training. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection, enough improvement had been made and the provider was no longer in breach of regulation 17.

● While the service completed regular audits of all aspects of the service, these audits did not highlight some issues around medicines management that we found. Management at the service rectified issues found at this inspection very quickly and by our second visit new systems were in place.

We recommend the service improves their governance systems to ensure any medication concerns are identified and addressed.

● The provider's registered manager was leaving the service. However, the service had already appointed a new manager who was already working at the service to enable a smooth handover.
● The provider understood its requirements under health and safety and completed necessary checks in relation to these.
● One relative told us, "Since [name of manager] has been there about 2 years now it has been running a lot better."
● The nominated individual supported the service with regular attendance at the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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
● People living at the home were happy and doing things they wanted to. Staff interactions were person centred. One person told us, "I am really happy here, I get to do what I want when I want, I like watching football and cricket, they support me to do this."
● We saw examples of individuals moving on from the service into more independent settings which provided good outcomes for people.
● One relative told us, "[Person] seems at home there, is happy and healthy and looked after well. [Person]

doesn't like change so they keep the same staff on duty when [person] is there which is really helpful. I call every morning when [person] is there and staff can always tell me exactly what they has been up to and how they are doing. So, I have a clear picture which I find really positive."

● The provider understood the duty of candour and completed the required notifications of incidents to both the CQC and local authority. The previous CQC rating was on display.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; continuous learning and improving care; working in partnership with others

● The provider engaged with people, relatives and professionals.

● One Relative told us, "We've not had to complain but we would if we had to. We would speak to the manager first. We have had questionnaires and we fill them in, but I don't think we could suggest anything. We are very happy with the home and the staff. We would recommend it."

● We saw examples of people's feedback, where possible and using this to change the service such as introducing a quiet floor.

● The provider worked well with external agencies as part of multi-disciplinary teams around individuals' health and social care needs.

● The provider conducted regular staff supervision which supported opportunities to engage with staff privately.

● The provider showed how they learn from incidents using lessons learned. The provider for example, had introduced trauma training for staff following some incidents.

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 12 HSCA RA Regulations 2014 Safe care and treatment Staff did not always follow the home's policy for medicines record keeping and administration