Welbourn Healthcare Ltd

Welbourn Hall Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Welbourn Hall is a residential and nursing care home providing personal and nursing care to 32 people aged 65 and over at the time of the inspection. The service can support up to 40 people. Welbourn hall has been converted into a care home and is divided into two units. The accommodation is spread over two floors.

People's experience of using the service and what we found
People's prescribed medicines were not managed safely. This included the ordering, administration, monitoring and guidance available for staff.

Risks associated with people's individual care needs were not consistently assessed, monitored and reviewed. Guidance for staff about how to mitigate risks were not consistently up to date and reflective of current needs.

Staff deployment was not sufficient in one part of the home. The provider took action and increased staffing levels. The staff training matrix showed gaps in all refresher training and nursing staff had not completed clinical training. Staff were recruited safely.

Staff knew how to report any safeguarding concerns, but guidance for staff on how to manage and mitigate known risks of harm and harm to others was limited.

Incidents were not effectively monitored and analysed to enable learning to reduce further risks.

The systems and processes to assess, monitor and improve quality and safety were ineffective. There was limited continuous learning to make improvements.

People and their relatives and representatives received limited opportunities to share their experience about the service they received.

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.

Overall infection prevention and control practice was good and the service was clean and hygienic.

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 1 September 2021).

Why we inspected
We received concerns in relation to the management of medicines. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led. only. 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 has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe 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 Welbourn Hall Nursing Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to how risks were assessed and managed, how medicines were managed, staff deployment, staff training and competency, the systems and processes that monitored the service and management oversight and leadership.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Welbourn Hall Nursing Home

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 completed by 2 inspectors, a pharmacist specialist 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 service.

Service and service type
Welbourn Hall Nursing Home Care is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Welbourn Hall Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

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

Notice of inspection
This inspection was unannounced.

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 work with the service.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with 3 people who use the service and 5 relatives to ask about their experience of the care provided. We observed staff interaction with people who use the service.

We also spoke with the registered manager, the director, two nurses, the registered managers assistant, a senior, 3 care staff, the cook and a domestic.

We looked at 14 care files along with a range of medication administration records. We looked at other records relating to the management of the service including staff recruitment, audits, health and safety, policies and procedures, meeting records, incidents and staff training and deployment.

Inadequate

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 good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

● Medicines were not managed safely. The procedures for ordering, storing, administering and monitoring medicines were not robust. This put people at increased risk of not receiving their prescribed medicines safely.

● Medicines stock checks found discrepancies of what medicines should have been available and what was in stock. A significant number of medicines could not be accounted for. This put people at risk of harm as we were unable to determine what had happened to missing medicines and if they had been administered. We made a safeguarding alert to external agencies.

● Information for staff of when to administer prescribed 'when required' medicines was limited. These medicines used at times of heightened anxiety should be used as a last resort. However, staff were not provided with guidance of what other strategies to use such as diversional techniques. Neither were staff advised to consider if a change of behaviour was due to a physical reason such as ill health. This increased the risk of people receiving sedative medicines which they may not have required.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● Care plans and risk assessments lacked detailed guidance for staff and were not always up to date and reflective of people's current needs. This put people at risk of receiving unsafe care and treatment.

● Guidance for staff about how to support people at risk of falls was not detailed. One person was at high risk of falling and had frequent falls. Guidance for staff of how to mitigate this risk included, 'staff to maintain frequent observations and whereabouts.' However, a senior care staff confirmed staff were not allocated to complete these checks, neither was it stipulated the frequency of checks required and that this needed to be recorded. The senior said, "We just do it between ourselves." We also noted the risk assessment did not include the use of a bedroom floor sensor; however one was used. This alerts staff to when a person is moving around. We were not sufficiently assured fall risks were managed safely and effectively.

● Discrepancies in care records about people's eating and drinking needs were identified. One person who had been assessed at risk of choking, required their food pureed and their fluids thickened. However, their care plan stated they required a textured diet, but gave no details of what this meant. Information in the kitchen stated a pureed diet but no details of their fluids. Whilst staff were knowledgeable about people's needs, information needed to be clear and accurate to reduce the risk of harm.

● Weight monitoring was not consistently effective. We identified from reviewing care records a person had lost 6 percent of weight loss in a month. There was no evidence of any action taken. The registered manager told us this had been discussed with the GP. However, we followed this up with the GP and found this was incorrect. This shows a lack of monitoring and oversight and increased the risk of harm.

● Health and safety checks on the premises and equipment had failed to identify risks. We identified 2 fire extinguishers were missing from their brackets. A care worker told us they had been moved as a person had

tampered with them and they were now locked in the staff toilet. There was no signage to indicate this. We were concerned care staff were not aware of this. Following the inspection, the provider forwarded information confirming staff had been informed. There was no room numbers or names of people on any bedroom upstairs, it was not clear which were bedrooms, and which were bathrooms and storerooms. This was a fire risk, and placed people at risk in the event they needed emergency evacuation. The provider took action to address these concerns.

The provider failed to ensure people's individual care needs had been fully assessed, monitored and action taken to mitigate risk. Environmental safety checks and monitoring were not robust. Prescribed medicines were not safely and effectively managed. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.
- At the time of our inspection, no person had a condition attached to their DoLS. Care plans were in place to inform staff of the DoLS and the expiry dates were monitored by the registered manager.

Staffing and recruitment

- Staff deployment was not sufficient to ensure people's individual care needs and safety were met. The provider used a dependency tool to assess people's care needs. However, it had failed to fully assess the individual care needs of people who lived or used the Willows. This was a separate wing of the home for people living with dementia. Two care staff were not enough to safely meet people's individual needs associated with their mobility, falls risk and emotional care needs. This increased the risk of harm. We discussed this with the provider and they immediately increased staffing levels to reduce this risk.
- Concerns were identified in staff refresher training and clinical training for nurses. The training matrix showed gaps in staff refresher training in all topics the provider had identified as required. There was no plan to confirm the action to reach full compliance. However, following the inspection, the provider forwarded information about training that had been planned for. Nursing staff had not completed clinical training. This increased the risk of people not receiving safe and effective care. This was raised with the registered manager and the local community health trust to review and follow up.

The provider had failed to ensure there were sufficient numbers of staff who had received ongoing training. This was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had safe staff recruitment procedures. This included, Disclosure and Barring Service (DBS) checks, this provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. Staff received opportunities to discuss their work.

Systems and processes to safeguard people from the risk of abuse

● Guidance for staff to protect people from the risk of abuse was not consistently detailed to mitigate known risks. One person had been assessed as a potential risk to others, due to some behaviours they could present. Guidance for staff of actions required to mitigate this risk was not sufficiently detailed. This increased the risk to people. We discussed this with the management team who agreed to follow this up.

● We observed one staff member supporting a person to walk in an incorrect way. For example, placing their hand under the armpit of the person they were supporting. This technique is unsafe and can cause injury. We raised this with the registered manager assistant who agreed to follow this up.

● Staff understood safeguarding procedures and their responsibility to protect people from abuse and harm. A staff member said, "We have a duty to keep people safe. Any concerns about abuse I would report to the manager."

● People and relatives raised no concerns about safety. A person said, "I'm looked after very well."

Preventing and controlling infection

● We were not fully assured that the provider was promoting safety through the layout and hygiene practices of the premises. The kitchen area in the Willows wing had a damaged worktop, exposing wood underneath and creating an infection hazard.

● We were assured that 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 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 responding effectively to risks and signs of infection.

● 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.

Visiting in care homes

● People were supported to maintain contact with their family and friends. Visits to the service were well facilitated. People and relatives raised no concerns about visits.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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; Continuous learning and improving care; 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 provider failed to establish robust governance systems to oversee the quality and safety of the service. As a result, people were placed at risk of receiving inappropriate or unsafe care.
- The audit checks and monitoring of medicines had failed to identify the urgent concerns and risks identified during this inspection. Records showed the registered manager had identified shortfalls in the management of medicines for over six months prior to this inspection but had failed to take robust action to make improvements. This put people at risk of harm.
- Incident governance, systems and processes that monitored falls and behavioural incidents were not robust. A lack of analysis impacted on the provider's ability to consider any themes, patterns and learning to mitigate further risks. This increased the risk of harm.
- The providers monitoring systems and processes of health and safety of the environment and staff deployment had failed to identify the concerns reported in the Safe section of this report. This lack of oversight and robust monitoring placed people at increased risk.
- The provider's audits and checks had failed to identify care plans did not provide staff with sufficient guidance of how to manage and mitigate known risks. This is in relation to managing falls risk and risks associated with people's emotional care and support needs. Where risks had been identified there was not always a corresponding risk assessment in place. This showed poor oversight and leadership and put people at increased risk of receiving unsafe care.
- Accurate care records had not been maintained. There were discrepancies in records relating to people's dietary needs. Where people required a specific modified diet, this was not consistently recorded or detailed to support staff to provide suitably modified food. We identified care plans and risk assessments had not been monitored or reviewed at the frequency the provider expected. This meant guidance for staff was not up to date and information did not reflect people's current care and treatment needs. This increased the risk of people receiving unsafe care.
- The provider had failed to effectively monitor staff training. There was no action plan to support staff to complete refresher training. It was a significant concern that nursing staff had not completed clinical training and their competencies checked. The showed poor oversight and leadership and increased the risk of people receiving ineffective and unsafe care.
- Oversight and leadership of the service was ineffective. The registered manager had frequently covered nursing shifts. This had a negative impact on their ability to manage, oversee and lead the service.

● The registered manager told us they understood their responsibility under the duty of candour to be open and honest when things went wrong. When we discussed with the registered manager concerns identified about nurse training, they assured us these staff had completed online clinical training. However, when reviewing records we found this to be incorrect. One nurse had completed wound care and catheter care. When we asked the registered manager about the action taken for a person who had experienced weight loss, they told us this had been reported to the GP. However, we followed this up with the GP and found this to be incorrect. This showed a lack of transparently.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● There was a lack of opportunity for people and relatives to share their experience about the service. A relative said, "There is a lack of surveys, newsletters or relative meetings." They also told us they had not been involved in the development or review of their family members care plans. This reflected other people's feedback.

● Following our inspection, the provider forwarded us information about how they enabled people and visitors to share feedback. This included, a suggestion box, complaints book, during communication and a survey had been sent during 2022 inviting people to share their experience.

The provider had failed to consistently assess, monitor and mitigate risks and to maintain accurate records, and to seek feedback about the quality of care and overall involvement and to maintain effective governance systems. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Another relative told us they had no concerns about any aspects of the service and that they would be happy to talk to either the registered manager or registered manager assistant saying, "They are both approachable."

● Staff received opportunities to share their experience of working at the service via staff meetings, daily handover meetings, daily heads of department meetings and supervision meetings. We received a mixed response from staff about how supportive and approachable the registered manager was. Whilst some staff were positive and spoke highly of the registered managers others felt they were not always listened to.

● The provider had met their regulatory responsibility by displaying their inspection rating outcome.

Working in partnership with others

● The service was supported by two GP practices and a community home health team of health care professionals.

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

● People and relatives were positive about the care and treatment provided. A relative described the care as, "Exceptional and done with kindness and compassion."

● Observation of staff engagement with people was positive, kind, caring and respectful.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess risks and do that is reasonable to mitigate risks. Regulation 12 (1) (2) (a) (b) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficient numbers of suitably, qualified, skilled and competent staff deployed to meet people's needs and safety. Regulation 18 (1) (2) (a)

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
Treatment of disease, disorder or injury	The provider failed to have proper medicines management systems and processes in place. Regulation 17 (1) (2) (g)

The enforcement action we took:

Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had failed to have effective systems and processes to monitor quality and safety. Care records were not consistently accurate. Regulation 17 (1) (2) (a) (b) (c)

The enforcement action we took:

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