

St Philips Care Limited

Bowburn Care Centre

Inspection report

Bowburn South Industrial Estate
Bowburn
Durham
County Durham
DH6 5AD

Tel: 01913778214

Website: www.stphilipscare.com

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service: Bowburn Care Centre provides accommodation, nursing and personal care for up to 80 older people. At the time of the inspection 66 people were using the service.

People's experience of using this service: During our inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to ensuring the safe care of people and dealing with complaints.

Staff were not adhering to people's percutaneous endoscopic gastrostomy (PEG) feed prescription. PEG feeding involves have a tube passed into a person's stomach through the abdominal wall to provide a means of feeding when oral intake is not adequate. staff were not following the prescriber's instructions in relation to PEG feeds.

Work was being completed to improve the care records and staff were producing more detailed assessments. However, the existing care records contained minimal information.

For some people risks were not clearly described or addressed, for instance one person was drinking very limited amounts of fluid and was at risk of severe dehydration. No risk assessment was in place. No action had been taken to explore with the GP alternative means to support them to remain hydrated.

Nutritional assessment tools were in place, and staff ensured people were encouraged to eat a balanced diet. However, we could not determine what action had been taken when people had lost weight or had very low Body Mass Index (BMIs) and therefore underweight.

People were not happy with the way complaints had been managed. The complaint records were incomplete. We were unable to track whether complaints had been responded to, investigated or resolved. The regional manager had identified this issue and was acting to resolve the matter.

Staffing levels met people's needs but until recently this had been problematic. There was regular use of agency nurses. We found that more consideration needed to be given to how agency staff were made aware of processes and practice at the service such as how to navigate the computerised care records, where to record fluids and where equipment such as suction machines were kept.

Medicine management had been improved over recent weeks and were much more robust. The clinical lead and staff had worked closely with the local Clinical commissioning Group (CCG) pharmacist to make positive changes to their practice.

We observed a lot of person-centred practice where staff worked with people in a very sensitive and empathetic manner.

Staff were able to alter the temperature of rooms but during changeable weather staff needed to have a system in place for checking heating so that room temperatures did not become excessively hot or cold.

Staff were aware of safeguarding procedures and we found these were acted upon. The clinical lead was very thorough and used incidents to determine lessons that could be learnt.

The activity coordinator was extremely proactive, and people were positive about the range of activities. A wide range of stimulating and innovative activities were provided. Their link work with other organisations was exceptionally good.

The regional manager, registered manager, deputy manager and clinical lead were critically reviewing the service and had identified improvements that needed to be made. Positive changes were being made but it was too early to see if these would be effective and if so sustained.

Staff told us the registered manager and deputy were approachable and closely listened to their views. They felt positive about how the service was now being operated.

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

Rating at last inspection: Good (report published 2 August 2017).

Why we inspected: We completed the inspection on the back of concerns, complaints and safeguarding raised from multiple sources, including members of the public, whistle-blowers and local commissioners.

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

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 always safe.

Details are in our Safe findings below.

Requires Improvement ●

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 always well-led.

Details are in our Well-Led findings below.

Requires Improvement ●

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or supporting someone using a care service.

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.

Notice of inspection: This was an unannounced inspection.

What we did: Before the inspection we reviewed information, we had received about the service. This included details about any incidents the provider must tell us about, such as any serious injuries to people. The provider had not been asked to complete a provider information return prior to our inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We asked the local authority who commissions the service for their views about it. We used this information to plan our inspection.

During inspection: We spoke with nine people who used the service and eight relatives. We also spoke with the registered manager, the regional manager, deputy manager, clinical lead, seven care staff, a domestic staff member, the administrator and two activities coordinator.

We reviewed a range of records. This included six people's care records, medicine charts and various records related to the management of the service.

Is the service safe?

Our findings

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

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. Regulations had not been met.

Assessing risk, safety monitoring and management.

- Staff were not adhering to a person's PEG feed prescription. Staff failed to make sure the individual received the right number of feeds and volume of fluids they required. One person was to receive taster food and fluid orally, but it was unclear what food and fluid they were to get. Not adhering to PEG feed prescriptions can adversely affect people's health.
- One person was currently experiencing distention of their stomach, which could have been related to mismanagement of the PEG feeds. The clinical lead had identified the change in the person's presentation and had contacted the Nutricia nurse (the regional nurse who supports people who receive PEG feeds) to ask for a review. However, they had not initially seen the discrepancy in the person's feeds but as soon as we brought this to their attention they acted and reported the matter to the local safeguarding team.
- Some of the nurses did not understand the implications of not administering PEG feeds correctly.
- The wrong syringes for giving the PEG feeds had been supplied and nurses had been using these even though they did not fit securely. This had been pointed out to the staff by a nurse and new syringes had been obtained. However, no one had unpacked them or informed the agency nurse that they were available, so they had continued to use the incorrect syringes.
- Risks to people were not always clearly described or addressed. For instance, one person had lost 11% of their body weight but we could not find what actions staff were taking to attempt to curb the weight-loss they were experiencing or explore underlying reasons.
- Some people were drinking a limited amount of fluid between 800 and 1000mls but there was no information to show what action staff were taking to ensure they did not become dehydrated.
- We noted that some of the emergency pull cords were tied up or wrapped around pipes in toilets and bathrooms making them inaccessible to people who may need to call for staff assistance. No one had made the agency nurse aware of where equipment such as suction machines were stored. This meant they believed these were not available so in the event of an emergency would not have used them.

The above concerns demonstrated a failure to provide care and treatment in a safe way and a failure to identify and assess potential risk of harm to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Work was being completed to refurbish the home and this had commenced. The management team were working with staff to ensure they brought faults or repairs to them in a timely manner. One window restrictor was missing from one of the ground floor units. Staff had noted this but not reported it straight away, which had left the unit vulnerable to risk that people might try to leave via this route. This matter had been addressed with the staff team.
- Equipment was appropriately maintained, and checks were routinely completed.

- Emergency plans were in place to ensure people were supported in certain events, such as a fire.

Staffing and recruitment.

- Staffing levels met people's needs but we heard from people, the registered manager and staff that until recently this had been problematic. During the day there was a nurse and 13 care staff on duty. Overnight there was a nurse and eight care staff on duty. In addition to this the registered manager, deputy manager, clinical lead, activity coordinators and ancillary staff such as a cook and domestic staff worked at the home.
- A person commented, "Sometimes they're short you can tell there's not so many there and the staff will tell you as well, I think they've got some more now."
- The provider operated systems that ensured staff were recruited safely.

Using medicines safely.

- Medicine management had been improved over recent weeks and were much more robust. Daily counts had been introduced and staff were made accountable for ensuring Medicine Administration Record sheets (MARs) were completed and accurate before leaving shift.

Systems and processes to safeguard people from the risk of abuse.

- Secure arrangements were in place to manage people's personal expenditure.
- People we spoke with had no concerns about safety in the home or any concerns about members of staff.
- Staff had been trained in safeguarding and safeguarding alerts had been sent to the local authority.

Preventing and controlling infection.

- Staff had access to aprons and gloves to reduce the effect of cross infection.
- Cleaning was on-going throughout our inspection. The home appeared clean and tidy with no odours.

Learning lessons when things go wrong.

- The clinical lead spoke with us about how as a team they had been learning lessons from incidents and events. Recently, they had worked closely with the Clinical Commissioning Group (CCG) pharmacist to improve medicine practices within the home.

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations had not been met.

Improving care quality in response to complaints or concerns.

- The provider had a complaints process in place, but this was not used effectively. We were unable to track whether complaints had been responded to, investigated or resolved. People told us they were dissatisfied with the way complaints had been managed.
- We could not verify if the registered manager had met timescales for dealing with complaints, as set out in the provider's complaints process. Acknowledgement responses were not sent out within the timescales defined in the company policy.
- Where complaints had been raised there was no record of any investigation being completed. The provider was unable to provide us with the outcomes for 11 of the complaints that had been made.

This failure to operate an effective complaints system is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We did note that the registered manager and regional manager had identified this as an issue and were starting to take steps to rectify this matter.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.

- The provider had purchased a new electronic system for documenting care records. Staff had begun to transfer information onto the new electronic records. However, the initial records only provided extremely basic information. Care records were being improved but were very variable with some being very detailed and others containing minimal information.
- Staff accessed the care records via a mobile phone. Staff told us there were variations in how well they could use this technology and not all the staff had access to the mobile phones. No information was available to support agency staff use these records.
- The regional manager and registered manager had identified these deficits and had begun to take steps to rectify them.
- People's needs were identified, including those related to equality, their choices and preferences. The service identified, recorded and shared information about the communication needs of people, as required by the Accessible Information Standard.
- Two activities coordinators were employed in the service. When they arranged activities, they considered people's abilities. Staff worked with the activities coordinator to enable people to join in.
- People who wished to be involved, watched singers perform. Some people enjoyed singing and dancing with four of the carers. There was a lot of fun, laughter and enjoyment in the faces of people sat watching or dancing.
- People had access to an enclosed garden with an aviary and rabbits. We discussed with the staff making this easier to get into by unlocking lounge doors, so people could readily go in. They completed appropriate

risk assessments, so people access outside areas independently.

- Religious services were held in the home and people were given the opportunity to participate in them.

End of life care and support.

- People were supported to make decisions about their preferences for end of life care, and staff empowered people and relatives in developing care and treatment plans. Professionals were involved as appropriate.
- Staff understood people's needs, were aware of good practice and guidance in end of life care, and respected people's religious beliefs and preferences.

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.

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations had not been met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

- The provider had identified that there were failures to deliver safe and effective care. They had recently employed a regional manager and they had been working with the registered manager to complete thorough audits. Detailed action plans were in place which outlined the improvements to be made, within specific time frames.
- The regional manager and registered manager were very open about the issues they had found.
- They had identified the concerns we found and were starting to put measures in place to rectify them.
- Work was being completed to improve the care records and create more detailed assessments. The most recent care records were very informative.
- The clinical lead had been working diligently to improve the nursing care being provided.
- The provider was actively recruiting nursing and care staff.
- The provider had ensured that a complete refurbishment programme had commenced at the service.
- Positive changes were being made but it was too early to see if these would be effective and if so sustained.
- Staff told us they felt supported by the registered manager.
- Statutory notifications about important events in the service had been made as required to CQC.

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

- The provider and registered manager positively encouraged feedback and acted on it to continuously improve the service. For example, following feedback from people they had worked with people and staff to make improvements to the environment.
- A relative commented, "The most important thing is the care of the people and it's not very often anyone seems agitated [family member] has settled in the home from day one."

Continuous learning and improving care.

- The provider had identified deficits in the old care records and a new electronic system was in place. Staff were still learning how to get the best out of the system and produce useful care records. The regional manager saw staff were struggling so had asked another manager from one of the sister homes to come each week and support staff to understand the technology.

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
Treatment of disease, disorder or injury	People using the service did not receive safe care and support. Staff had not ensured all risks were identified and management plans for known risks were not always followed. Regulation 12(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
Treatment of disease, disorder or injury	The provider had failed to establish and operate an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons. Regulation 16 (2)