St Philips Care Limited

Welbourn Manor Care Centre

Inspection report

High Street
Welbourn
Lincoln
Lincolnshire
LN5 0NH

Tel: 01400272221
Website: www.stphilipscare.com

Date of inspection visit:
06 October 2021

Date of publication:
08 November 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Welbourn Manor Care Centre is a residential care home providing accommodation and personal care to 21 people aged 65 and over at the time of the inspection. The service can support up to 31 people.

People's experience of using this service and what we found
People were not always protected from abuse. Monitoring from the registered manager around staff practices, had allowed a poor staff culture to develop at the service. The provider's whistle blowing processes had highlighted concerns and the provider had acted swiftly to address the concerns to ensure people's ongoing safety.

The risks to people's safety were not always well managed. People's falls were not managed safely. Fire safety information was not up to date. Management of people's medicines was unsafe. People were exposed to environmental risks as some sluices and a cupboard containing COSHH chemicals were not locked. Staff recruitment processes were not always robust.

There was a lack of registered manager oversight in several areas of care, this included staff behaviour and practices and management of day to day care and treatment.

Quality monitoring tools had not been used effectively and had impacted on the care people received.

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 Good (published 23 March 2020).

Why we inspected
We received safeguarding concerns regarding the people living at the service. As a result, we undertook a focused inspection to review the key questions of safe 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 requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

The provider took steps to ensure people's ongoing safety at the service following our inspection
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Welbourn Manor 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 safeguarding, management of risk, monitoring the quality of the service.

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 request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information 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?

Inadequate

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.

Welbourn Manor 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.

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 service was inspected by two inspectors.

Service and service type
Welbourn Manor Care 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.

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. At the time of the inspection the registered manager had been suspended by the provider while they undertook investigations into safeguarding concerns. An interim manager had been placed at the service to provide support.

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 prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and one relative about their experience of the care provided. We spoke with five members of staff including the regional support manager, interim home manager, care workers, laundry assistant and the interim chef. We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to review records and seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

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.
Assessing risk, safety monitoring and management;
● The risks to people's safety were not always managed safely and actions were not taken to mitigate risks to people.
● Risks to people who were more likely to have a fall were not managed safely. One person had fallen 21 times from 1 May 2021 to 6 October 2021. Thirteen of these falls were sustained in the person's bedroom at night and were unwitnessed. The person's care plan lacked information on measures to reduce the risk of falls. A further person had suffered nine falls since 1 May 2021, six of these falls happened in their room at night. Again, there was no information in their care plan to show measures had been considered to mitigate the risk of falls and reduce the risk of injury.
● People were at risk from fire related incidents. We saw the fire safety folder which contained people's personal emergency evacuation plans (PEEPS). However, we found the information in the fire folder was out of date and incorrect. For example, three people who had left the service were still listed as residing there and three people who lived at the service did not have PEEP's in place. This meant people were at risk because plans on how to evacuate them during a fire were not present.
● During our inspection we found two sluices and one cupboard had COSHH (control of substances hazardous to health) chemicals in but were not locked. This presented a risk people who lacked capacity could ingest the chemicals causing harm or injury.
Using medicines safely
● Management of people's medicines was unsafe and there was a lack of clear consistent information to support safe administration of medicines.
● There had been a lack of oversight of the management of medicines. This had resulted in some people not receiving their medicines as prescribed. Controlled drugs were not stored safely, there were insufficient stock levels of some medicines resulting in people not receiving medicines which should not be stopped abruptly. Out of date medicines were being stored in the drugs trolley and there was a risk they could be used for people.
● Staff had not been using the provider's electronic medicine administration records (E-MAR) correctly so this had been removed. However, the paper-based system put in place lacked photographs of people, no information on their preferences of how they took their medicines or information on when and why as required medicines should be administered to people.
● The provider had needed to bring staff to support the service from other homes. These staff were not familiar with the people they supported, and the lack of information meant there was a risk to the safe administration of medicines.

The provider failed to ensure that risks to the health and safety of people was well managed. This included

risks associated with the management of their medicines. The above concerns show a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.
● The interim manager immediately addressed our concerns around the information in both the paper based MAR system and the fire safety folder and ensured peoples personal emergency evacuation profiles (PEEP's) were up to date. They instructed the estates team to put locks on the doors of rooms and cupboards containing COSHH chemicals.

Systems and processes to safeguard people from the risk of abuse
● People living at the service were not always safe from abuse. Recent safeguarding concerns had been raised via the provider's whistle blowing processes around alleged abuse which included neglect, verbal abuse, and physical abuse. These allegations were being investigated by the provider and the local safeguarding teams. The findings will be shared with the external agencies as required.
● The provider found there was a lack of monitoring from the registered manager around staff practices, this had allowed poor culture to develop at the service. Some staff we spoke with told us there was a culture of bullying among staff to both people living at the service and other staff. This had resulted in people being excluded and incidents of behaviours being managed in a dictatorial way.
● A relative we spoke with told us staff had recounted incidents involving their family member putting the onus of blame on the person.
● The provider's safeguarding policy stated safeguarding training would be updated on an annual basis. the training matrix provided to us on the 11 October 2021 showed all the staff listed had not received this update training. There was a risk this lack of updated training had impacted on staff knowledge and understanding of reporting concerns.
The provider failed to ensure that people were protected from abuse and improper treatment. The above issues show a breach of Regulation 13 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

● Following the whistle blowing concerns being raised the provider had acted swiftly prior to our inspection to ensure the safety of people at the service by suspending staff while investigations took place as per their safeguarding policy. They continued to work openly with the local safeguarding teams and CQC to ensure robust investigations were undertaken.
● One person we spoke with said, "New carers are not the same as before. Things have improved since care staff have changed. All the staff who were not nice have gone now. Feels safer now."

Recruitment and staffing
● Recruitment processes were not always robust. We looked at staff files and found one staff file to have a gap in the employment history which had not been identified during interview or followed up. This put people at risk of receiving care from people not suitable for work in the adult social care setting
● Although the provider had suspended several staff, they ensured people were supported by adequate numbers of staff. They also worked to support staff by bringing an experienced interim manager to the service to support staff to make improvements to the quality of the service.

Learning lessons when things go wrong
● The registered manager and staff had not used tools available to them to review events and learn from them. The information above on the safeguarding issues, management of falls and medicines show a lack of oversight. This had resulted in people receiving poor care.

Preventing and controlling infection

- 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 using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- 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.
- We were assured the provider was facilitating visits for people living in the home in accordance with the 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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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.

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

● People's care plans were not always person centred and lacked details. For example, one person who due to their confusion, had several episodes of anxiety, resulting in several incidents being recorded. The information in the incident records had not been analysed and their care plan not updated to reflect how staff should support the person reduce their anxieties or keep them safe.

● The training matrix we received on 11 October 2021 showed several staff required update training in areas such as dementia, distressed signs, reactions and behaviour and safeguarding training to support their knowledge of how to deal with these types of incidents. This lack of up dated training and lack of registered manager's support impacted on the way staff cared for people.

● Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

● There was a lack of monitoring of staff practice in relation to their behaviours and attitudes towards the people they supported. There was a lack of meaningful supervisions for staff. Records did not show any evidence of staff being supported to discuss individual concerns.

● Staff told us the registered manager was not always accessible. They had been told by other senior staff not to go to the registered manager with concerns as they were busy and to take their concerns to the deputy manager or one of the senior care staff. Staff we spoke with told us there was a culture of bullying at the service and this included upward bullying towards the registered manager.

● Staff did not feel supported. One staff member told us they had not liked coming to work for a long time. They went on to say it was only since the whistleblowing concerns had come to light and the provider was taking actions to address the issues, they felt more comfortable working at the service.

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

● There was a lack of registered manager oversight in several areas of care, this included staff behaviour and practices and management of day to day care and treatment. Quality assurance tools had either not highlighted when people's care had fallen below the standard of care expected from the service, or actions highlighted had not been followed up. This included for example, the concerns highlighted in the safe section of this report around people's falls, and management of their medicines.

● There was no evidence found to demonstrate the analysis conducted by the provider's quality monitoring team via their monthly quality monitoring reports dated 11 August 2021 and 23 September 2021, had been shared with the registered manager. This lack of communication between the quality monitoring teams and the service impacted on the care people received.

The provider failed to ensure that their systems and processes were working effectively, and people were receiving a safe and good quality service. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had taken swift action to address the concerns in relation to medicines, their audit on 1 October 2021 had identified the above concerns of medicines not being administered as prescribed, storage of medicines, stock levels and out of date medicines and addressed the concerns.

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 had been open and honest when dealing with recent issues around safeguarding at the service. Although we had received statutory notifications from the service as they were required by law to report to us. The registered manager had not submitted a small number of historical notifications. This had been highlighted by the provider and we were assured processes were in place to address this moving forward.

Working in partnership with others

● There was evidence to show a lack of partnership working with health professionals had impacted on people's care. Instructions from health professionals had not been carried out. For example, a health professional who supported one of the people at the service had recorded in their care plan their medicines dose was to be reduced. This instruction had not been carried out by staff.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from abuse.