

Vesta Care (UK) Limited

# Paul Murphy Centre

## Inspection report

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19 March 2021

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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 eight people with a learning disability and / or autism. Four beds were allocated for people to access short respite stays at the home. At the time of our inspection, two people were living at the Paul Murphy Centre. There was no one accessing the respite service on the day of our inspection.

The home is an adapted, refurbished property with twelve bedrooms, some of which are en-suite. There are two shared lounges and a shared kitchen / diner. There is an accessible garden to the rear.

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

The deputy manager reviewed a range of documents each month. However; the provider had not had robust oversight of the service to support the deputy manager. The provider had not ensured regular checks of the fire safety systems had been completed. Plans were in place to improve the quality assurance systems.

Relatives were positive about the support provided, the communication with the staff team and felt their relatives were safe at the Paul Murphy Centre. Staff were also positive about working at the service and the support they received, especially from the deputy manager. Formal staff supervisions and meetings were planned for the coming year.

The risks people may face had been assessed and guidance was in place for staff to manage these known risks. People received their medicines as prescribed.

There were enough staff on duty to meet people's needs. The number of staff on shift varied depending on how many people were at the home for a respite stay. Staff had been safely recruited.

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 the underpinning principles of Right support, right care, right culture.

### Right support:

People's needs were assessed to ensure people received the support they needed. These were reviewed with their relatives before each respite stay to ensure any changes in needs were known.

### Right care:

Support was person-centred and promoted people's dignity and privacy.

#### Right culture:

Staff were positive about working with people at the Paul Murphy Centre. 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. People were supported to access the community whenever possible, considering the COVID-19 restrictions.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

#### Rating at last inspection

The last rating for this service was good (published 15 April 2019).

#### Why we inspected

We received concerns in relation to the management of medicines, staffing and the management and oversight of 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.

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 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.

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](http://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 the quality assurance systems and provider oversight at this inspection.

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

#### 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?**

The service was not always safe.

Details are in our safe 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** ●

# 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 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 inspection was carried out by one inspector.

#### 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.

The service did not have a manager in post registered with the Care Quality Commission. The home was being managed by the deputy manager at the time of our inspection. A registered manager 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 inspection was unannounced.

Inspection activity started on 11 March 2021 when we visited the Paul Murphy Centre and ended on 19 March 2021.

#### 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 observed staff interacting with two people who used the service and spoke with four relatives about their experience of the care provided. We spoke with six members of staff including the business manager (who is also the Nominated Individual), deputy manager and support workers. 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 three people's care records and medication records. We looked at three 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 seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We contacted three professionals who regularly visit the service and received one response.

# 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 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.

### Assessing risk, safety monitoring and management

● Weekly and monthly checks for the fire alarm, fire doors, fire extinguishers and emergency lighting had not been completed since November 2020. The staff member completing these checks had left and no one else had been delegated to carry them out. Fire drills had not been held since June 2019. This meant the service had not checked the fire safety system was in working order.

The lack of management oversight to ensure the checks on the fire safety equipment were delegated to a trained member of staff and had been completed was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Training had been arranged for mid-March for staff to be able to complete these checks and to complete a fire drill.
- Equipment was serviced, checked and maintained in line with regulations and manufacturer's instructions.
- Individual risk assessments were in place for people who lived permanently at the home and guidance provided for staff in how to manage these known risks. However, one person who was at risk of losing weight was not regularly weighed to monitor any weight loss or gain so their support plan could be fully reviewed. Following the inspection, we were told the service had purchased a specialist weighing machine so the person could be weighed regularly.
- The risks and associated staff guidance were reviewed before each respite stay to check if there had been any changes since the person's last visit. The information for a person new to the respite service was not fully completed, with the care plan being added to as the staff got to know the person. The person's family told us, "The staff are pro-active in getting the information they need so that [Name's] time there is positive."
- Some people who used the respite service could become anxious or agitated. Most staff had completed training in managing people's behaviours. Practical face to face training had been booked for the end of March 2020. Incidents were recorded and care plans updated to take the incident into account.

### Staffing and recruitment

- Rotas showed there were sufficient staff on duty to meet people's needs. Staff told us that the number of staff on duty changed depending on how many people were using the respite service.
- Regular agency staff were booked when required, who were given sufficient information about people's needs to be able to support them safely.
- New staff were safely recruited, with all pre-employment checks being made before the staff started working at the Paul Murphy Centre.



### Using medicines safely

- People received their medicines as prescribed. Guidelines were in place for when any medicines not routinely administered were to be used.
- Medicines administration records were used to record all medicines administered. Weekly and monthly checks were made to ensure all records were completed, check stock quantities, medicines re-ordering and review staff training was up to date. Action plans were written for any issues found and these were discussed with individual members of staff.

### Preventing and controlling infection

- The home was very clean throughout.
- Policies and risk assessments had been updated to take into account COVID-19. Suitable PPE was available and used appropriately. Staff and people living at the home were part of a regular testing programme. Where people lacked the capacity to have a COVID test a best interest decision had been made involving relatives and professionals.
- The home had two lounges which meant people using the short breaks respite service could remain separate from those living at the home all the time to reduce the risk of spreading Covid-19. The staff on duty were also allocated to support either the people on a short break or those living at the home all the time.

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

- The deputy manager reviewed all incidents and accidents for any patterns, for example the same member of staff being involved or similar times of the day.
- Some people who used the respite service could become anxious or agitated. Most staff had completed training in managing people's behaviours. However, we saw there had been a recent incident involving a new person accessing the respite provision as the service had not been made aware of a potential trigger for their behaviour. The incident had been recorded and care plans updated to take the incident into account.
- Members of staff completed safeguarding training and said they would report any concerns they had to the deputy manager. Relatives told us they felt their relative was safe being supported at the Paul Murphy Centre.

# 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.

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

- The registered manager had left in October 2020. A manager had been recruited but had not applied to the CQC to be registered and had left in February 2021. The Operations Manager overseeing all the providers services had also left in February 2021. We found the Operations Manager had not completed any audits of the service since September 2019. The senior management team were not aware of this. This meant there had not been a robust oversight of the service by the provider.
- The quality assurance system was not robust. The deputy manager reviewed a range of records, including incidents, accidents medicines and falls each month. They also reviewed up to three care plans. However; since the last registered manager left, they have not had the support to discuss their findings with a manager. The deputy manager also writes the care plans and so should not audit their own work. The deputy manager had not been able to complete these checks since January 2020 due to having to manage the service.
- Observations of staff competencies had not been regularly completed, for example for moving and handling and enteral feeding.

The lack of a robust quality assurance system was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider was in the process of reviewing the quality assurance system and was planning to introduce a timetable for when all the required audits were to be completed and all equipment checks and servicing were due.
- The provider was also introducing clearer roles for team leaders to review care plans and to utilise the reports that could be generated by the electronic care planning system to evidence that activities and reviews were taking place.

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

- Staff said the staff team supported each other and they enjoyed working at the Paul Murphy Centre. One member of staff said, "All the team are really supportive and will help me if I ask them."
- CQC had received two whistle blower alerts concerning staff at the service. The deputy manager told us these had been investigated and no evidence had been found to substantiate the claims. They also said,

"Staff morale is better than it was since some of older staff left. We're getting new staff in and it's a fresh start."

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

- Relatives we spoke with were all positive about the Paul Murphy Centre. They said communication was good, they felt listened to and their main contact at the home was the deputy manager. One relative said, "They listened to us. Everyone was positive and wanted the best for [Name]. They were pro-active about getting the information they needed so [Name's] time there is positive."
- Staff said they felt well supported in their roles. One member of staff said, "[Deputy manager] has provided stability for the team; we've always had support from them. [Deputy manager] and [training manager] organise things at the moment."
- Staff meetings and supervisions had not been regularly held, but the staff said they were able to speak with the deputy manager or training manager if they had any concerns. The Nominated Individual showed us a timetable for supervisions throughout 2021, which were to be completed by team leaders and the deputy manager. Staff meetings were also being arranged by the deputy manager, with the first one having taken place.

Working in partnership with others

- The home had worked well with medical professionals during the COVID-19 pandemic. Relatives told us that the relevant medical professionals were involved with their relative when needed and they were kept fully informed if their relative became unwell. One relative said, "They get the right people involved early and rang me straight away that they were doing this."
- A professional who works with the service was also complimentary, saying, "The management team have been timely in raising areas that they need support with and have worked in a collaborative way to ensure that the person's needs were met in a person-centred way."

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 Nominated Individual was open with the inspector around the shortfalls that had been identified within the management of the service and the actions being taken to address them. They understood their legal responsibilities.
- The CQC were notified appropriately of any incidents at the service.

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 17 HSCA RA Regulations 2014 Good governance  There was a lack of a robust quality assurance system and provider oversight of the service.  The provider had not ensured the checks on the fire safety equipment had been delegated to a trained member of staff and were being completed