Wellbeing Care Limited

Wellbeing Care Support Services

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 5 March 2015 and was unannounced.

Our previous inspection of 20 May and 17 June 2014 had identified concerns with the training of staff, how risks to the service were managed and how the service assessed and monitored the quality of the service provided. At this inspection we found these concerns had not been addressed.

The service provides personal care and support to adults with a learning disability who live in a small block of flats owned by the provider. On the day of our inspection there were seven people receiving support from the service.

There was no registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

People's safety was compromised in a number of areas. This included being exposed to avoidable harm and the management of people's medicines. Staff did not demonstrate that they had the required knowledge to be able to safeguard people and report any safeguarding concerns to the relevant safeguarding authority.

Staffing levels were insufficient to meet the needs of people who used the service. The provider did not have a system in place to ensure continuous assessment of staffing levels and make changes when people's needs changed.

The provider did not operate a safe and effective recruitment system. People were put at risk because when Disclosure and Barring (DBS), criminal records checks revealed staff had relevant records no actions were in place to assess or mitigate any risk.

We were not assured that people's choices and rights were being respected. Staff had not received training in the Mental Capacity Act 2005 (MCA). No applications has been made to the Court of Protection when people my require restraint to be used. They were not fully meeting the requirements of the Mental Capacity Act 2005.

People had not always been supported to access, when needed, the support of health care professionals. People had not been supported to attend follow-up appointments, for example to a dentist.

The service was not run in the best interests of people using it because their views and experiences were not sought. Improvements were needed in the way that the service obtained people's views and used these to improve the service.

There was insufficient planning to support people's wishes and preferences regarding how they wanted to be cared for. There was also insufficient planning to promote and support people's individual leisure interests and hobbies. We were therefore not assured that the planning and delivery of care supported people's individual needs, wishes and preferences.

We found there to be a number of continued breaches. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 safe.

Staff had not received training in protecting vulnerable adults from abuse and did not know how to make a safeguarding referral.

Risks to people whilst accessing the community were not assessed and people were not supported to access the community safely.

Staffing levels were not assessed and monitored. Safe recruitment procedures were not always followed.

People's medicines were not managed so that they received them safely and effectively.

Inadequate

Is the service effective?
The service was not effective.

People did not receive care that was based on best practice. Staff had not received effective support, induction, supervision, appraisal and training.

People's consent was not obtained. Where restraint was used the correct authorisations had not been sought.

People were not supported to access healthcare professionals such as optician and dentist.

Inadequate

Is the service caring?
The service was not caring.

Staff did not treat people with respect.

People were not able to express their views about their care.

Requires improvement

Is the service responsive?
The service was not responsive.

Care plans either did not exist or did not contain enough up to date information about people's needs for staff to deliver responsive care.

The provider did not have a system for logging complaints, concerns and suggestions.

People did not have opportunities to air their views regarding the quality of the care.

Inadequate

Is the service well-led?
The service was not well led.

The management of the service lacked direction and positive leadership.

Inadequate

Summary of findings

People were put at risk because there was a lack of systems for monitoring the quality and safety of the service.

The provider did not identify, assess and manage risks relating to the health, welfare and safety of people

Wellbeing Care Support Services

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 March 2015 and was unannounced.

The inspection was carried out by two inspectors.

People receiving care from the service were not able to speak with us about the care they received. We spoke with a relative of a person receiving support, a person who had recently received care from the service, the manager of an adjacent service owned by the same provider who was overseeing the service, the team leader and one member of staff. We observed support being provided to one person.

Prior to the inspection we reviewed records our records relating to the service including safeguarding referrals. As part of the inspection we reviewed care records relating to three people receiving care and available records relevant to the management of the service such as staff training records.

Inadequate

Is the service safe?

Our findings

People were not protected from abuse and avoidable harm. Safeguarding investigations we reviewed prior to our inspection showed that people had not been protected from avoidable harm and abuse.

Staff told us that they had not received training in safeguarding vulnerable adults. Records we reviewed confirmed this. There was no information available to staff on how to recognise signs of potential abuse and what to do if they had a safeguarding concern. For example in a flat being used as an office there was no information displayed regarding complaints, whistle blowing or safeguarding.

Risks to individuals were not managed so that people were protected and their freedom was supported and respected. Safeguarding investigations, which have been substantiated, showed that people were not supported to access the community safely. Care staff supporting people to access the community had not managed risk appropriately.

We saw that two people's flats were locked and the person did not have access to the key. The care plans for both of these people were written in October 2013 and had not been reviewed up to the date of our inspection. They did not contain any evidence that the person had been involved in the decision to lock the door. Staff were not able to tell us if any risk assessments or best interest decisions were in place to ensure that this was the least restrictive option for the person. Risk management policies and procedures were not in place to minimise restrictions on people's freedom.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

There was no system to assess the staffing needs of the service and we were not assured that there were sufficient staff to provide care. Staff told us that they were regularly asked to cover at short notice and had not been able to take holidays because there were insufficient staff to cover. The team leader told us that one person had been assessed as requiring an increase in their care needs from one person to two and that funding had been agreed for this. However, the service had been unable to provide the second member person due to lack of staff. We were unable to check records relating to this as the service had not kept its own records and the person's care plan which was kept in their property was not accessible. We requested the team leader to provide a breakdown of the staffing levels against the needs of people for the three weeks prior to our inspection. They told us they would do this and send it to us. This has not been received.

Safe recruitment procedures were not followed. One person's recruitment file showed that they had received a police caution. There had been no consideration as to whether this person was suitable to provide care to vulnerable people and no risk assessment or monitoring was in place.

Staff told us that they had received training in basic infection control and nothing else. Records we saw confirmed this. People receiving support from the service had a variety of complex needs including challenging behaviour, epilepsy and drug and alcohol abuse. If a person had an epileptic

seizure staff were not trained to deal with this safely and appropriately. We observed one person exhibit challenging behaviour during our inspection. The staff member who was supporting this person had not been trained in how to deal with situations of this type.

This was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Our medicines inspector looked at how information in medication administration records and care notes for people living in the service supported the safe handling of their medicines. We conducted an audit of medicines which considered people's medication records against quantities of medicines available for administration. We were unable to account for most medicines that we looked at and found numerical discrepancies. We noted many gaps in records of the administration of people's medicines. Therefore we were unable to determine that medicines had been administered to people using the service as intended by prescribers. We also noted that staff did not always use correct codes to record when people did not take their medicines. We found strong evidence for one person indicating that their medicine had been administered incorrectly, which may have impacted on their health and welfare. The team leader on duty at the time of our inspection showed us that a system had recently been put in place to account for medicines but

Inadequate

Is the service safe?

staff had not used it properly. We concluded that the auditing system was therefore ineffective at monitoring and promptly identifying issues arising in relation to the administration of people's medicines.

We looked at supporting information available to assist staff when administering medicines to individual people. We noted there to be a lack of written guidance or care planning relating to the assessed support people needed with their medicines. One person, who managed their own medication, had no risk assessment carried out to determine if they were able to safely manage their own medicine. There was no written guidance for staff to refer to about the administration of medicines prescribed for occasional (PRN) administration. There was no written guidance about the administration of people's medicines when concealed in food or drink (covertly) in their best interests when they lacked mental capacity and we found no evidence that assessments of their mental capacity had been done. This meant we could not be assured people were administered their medicines safely and when appropriate.

One person had recently had a prescriber review of their medicines and some medicines had been discontinued. Whilst we noted the medicines had been deleted on medication charts, we found there to be no records about this in their care notes and so safe record-keeping procedures had not been followed.

The manager confirmed to us that of eight members of care staff authorised to handle and administer people's medicines at the service, only three had received training on the management of medicines. For a person prescribed a medicine for the urgent treatment of epileptic seizures, only one member of staff had received specialist training required for the administration of the medicine. This member of staff was not on duty at the time of our inspection. The manager also confirmed that no member of staff had recently been assessed as competent. Therefore, we could not be assured that people using the service were administered their medicines by staff who were trained and assessed as competent to undertake these tasks.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

At our last inspection we were concerned with regards to the provider's lack of action to carry out appropriate supervision and appraisals of staff. At this inspection we found that staff were still not receiving appropriate supervision and appraisal. The provider had not taken the action required to protect people following the identification of concerns at the last inspection.

We looked at the personnel records of four care staff. None of the four staff had received any induction training programme. This would have provided them with the skills and knowledge they need to meet people's needs. Newly appointed staff confirmed that they had not received any induction training to support them in their role. One new member of staff told us that before providing care on a 1:1 basis with a person the only introduction to care they had received was two shadow shifts.

Staff told us that they had not received training relevant to their role. They told us that all the people receiving care and support displayed challenging behaviour to a greater of lesser degree. They told us that they had had not received training in breakaway or challenging behaviour and this was confirmed by records we inspected. They described situations where people they cared for were violent and told us they did not know how to de-escalate the situation. In one case this had resulted in the police being called and the person being sectioned under the Mental Health Act.

There had been a continued breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's records did not identify whether or not people had the capacity to make decisions about their everyday lives. There was no guidance for staff on actions they should take if a person lacked capacity to make specific decisions or if guidance had been sought in order to arrange for people qualified to do so to make decisions in their best interests.

We observed during our inspection that two people had the door to their flat locked and a carer was present with them. One person's records recorded that the door to their flat should be kept locked to ensure their safety. The other person's records did not refer to the locked door but we confirmed with staff that the door was kept locked. There were not records of best interest decisions or risk assessment with regard to the locked doors.

We saw in one person's records that when accessing the community they should wear a handling belt with reins as otherwise they would run off. Staff confirmed that the handling belt was being used. Staff were unable to tell us if the use of this restraint had been correctly authorised. There was no record of an application to the Court of Protection for a deprivation of liberty. There no records to show that the need for restraint had been assessed and the least restrictive option was being used.

Staff had not been provided with training in understanding their roles and responsibilities with regards to the Mental Capacity Act 2005 (MCA). They lacked understanding of Mental Capacity Act 20015 and what action they should take if someone's freedom of movement was restricted.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service did not support all of the eight people with food and drink. However, we saw in three people's records that their food and fluid intake had been monitored. We asked one person who had recently stopped receiving support why their food and fluid intake had been monitored, they told us they had no idea. The records relating to people's food and fluid intake were not fully completed and for some people there were days when nothing was recorded. We asked staff why records were being kept and they were unable to tell us. There was no monitoring or records which would have shown if the person was not receiving adequate food or hydration.

We observed one member of staff asking a person what they would like to cook for their dinner. The person was unable to tell the care worker what they would like. The care worker did not know what was available in that person's flat to prepare a meal. There was no planning or support for this person to receive a balanced diet that promoted health eating.

People were not supported to maintain good health, have access to healthcare services or receive on going health care support. For example we saw in one person's records that they had been supported to access outside professionals such as a dentist and optician regularly until 2013. From 2013 there was no record of any such

Inadequate

Is the service effective?

healthcare support. Staff were unable to tell us if these had taken place. Another person's records showed a visit to a psychiatrist in August 2014. This record showed a follow-up visit was required in three months. There was no record of this visit taking place. We asked staff if this visit had taken place and were told that they thought it had been done the day before our inspection. There was no record of an appointment for this visit.

Requires improvement

Is the service caring?

Our findings

Safeguarding investigations and incidents that we are aware of, show that staff did not treat people with kindness and compassion but used the good will of the person to their own benefit. A relative we spoke with told us how this had taken place. They told us that since moving into the service their relative had, "Become mentally worse than they have ever been." They gave us examples of how their relative's behaviour had changed.

The service did not involve people in decisions about their care. A relative told us that since their relative has moved into the service a year ago, they have not been involved in any care planning or reviews. We saw in one person's care plan contact details for an advocate. We spoke to the advocate who told us that they had supported the person when they had moved into the accommodation a number of years ago but had not been contacted since. Care plans we looked at did not show that the person had been involved in making decisions about their care and support.

We saw in one person's flat a poster which told them how to react when they were given instructions by staff. It demonstrated symbols that showed staff would be happy if the person complied with their instructions. This poster was inappropriate.. Staff had not received training in different methods of communicating with people with complex needs. We saw a person interacting with a care worker, their behaviour was becoming increasingly challenging and the care worker had no structure in the way they were dealing with it. We left the flat as the manager from the adjacent service believed our presence may be aggravating the situation. The care worker had received no training in supporting the person when they displayed this type of behaviour whilst supporting their dignity and human rights.

Inadequate

Is the service responsive?

Our findings

We were able to ask one person about their care planning. They responded by directing us towards some paperwork and saying, "It's there, nothing to do with me." Relatives we spoke with told us they had not been involved in any care planning or reviews of care. This despite them asking when a review would take place. They told us that the service did not provide them with information about their relative's care either informally by telephone or in a review meeting. Staff we spoke with told us that the two care plans we had looked at were the only care plans in place for the eight people living in the service.

The care plans which were available had not been reviewed in two years. They did not reflect how people would like to receive their care and support. For example, one of the care plans dated October 2013 detailed the activities a person took part in during the week. We asked staff if this person was still supported to carry on this activity. They were unable to tell us if the person was still being supported to attend the activities or if they still wanted to.

Staff told us that all of the people living in the service demonstrated some form of challenging behaviour. The absence of a care plan, or an out of date care plan, meant that there was no up to date assessment of risk or guidance to staff on managing this behaviour. For example we saw in person's care plan a risk assessment dated 22 October 2013. This stated that the person should not be allowed access to certain types of equipment. We saw that the items referred to were available in this person's accommodation.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked the staff and the manager from the adjacent service if there was a complaints procedure and if any complaints had been received. They told us they were unaware of the complaints procedure or records of any complaints being received. No complaints procedure or record of complaints could be found, despite staff searching the empty flat which was being used as an office.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us that no residents or relatives meetings had been held in the last six months to gain feedback from people regarding the quality of care.

Inadequate

Is the service well-led?

Our findings

This service was not well led. There was a lack of direction and leadership was weak. A relative we spoke with told us, “The place is run as a social club.” We were aware, prior to our visit, that staff had expressed concerns to visiting social workers about lack of training and support from the management of the service. We asked the manager from the adjacent service for a copy of the Statement of Purpose of the service. They were not aware of what this contained or how to access it.

The service did not have a registered manager in place. The manager from the adjacent care home told us that they had initially been recruited to manage both the care home and this service but they now felt they were not able to effectively manage both and that another manger was being recruited to manage this service.

Staff were not adequately supervised, trained and supported. This had resulted in staff and people receiving care, becoming involved in inappropriate scenarios because professional boundaries had not been established. Newly employed staff had not received induction training. There were no records of staff meetings or individual staff supervisions. The team leader confirmed that none had taken place for the last six months. We observed, in one person’s flat, a laminated homemade poster which described how they should behave. This poster was inappropriate and we brought it to the attention of the manager from the adjacent service.

People were not protected against the risk of unsafe or inappropriate care. There were no systems in place to identify, assess and manage risks to people who used the service and others. The manager told us that no environmental risk assessments had been carried out to ensure care was being provided in a safe environment. They also confirmed that no audits had been carried out that would identify medication errors or health and safety risks to individuals such as the use of equipment.

There were no systems in place to monitor the quality of the service provided. People were not asked their views on the quality of service they received either by way of meetings or quality assurance surveys. We asked to see any quality assurance surveys the service had carried out to gain people’s views of the quality of care they received. The team leader and manger from the adjacent service told us they were not aware of any that had been carried out. No records of such surveys could be found.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

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
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The service was not ensuring the care and welfare of people who used the service.**

The enforcement action we took:
We have issued a Notice of Decision to restrict new admissions to the service.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The service did not assess and monitor the quality of service provided.**

The enforcement action we took:
We have issued a Notice of Decision to restrict new admissions to the service.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **People were not safeguarded against abuse.**

The enforcement action we took:
We have issued a Notice of Decision to restrict new admissions to the service.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Medicines were not managed and administered safely and effectively**

The enforcement action we took:
We have issued a Notice of Decision to restrict new admissions to the service.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Arrangements were not in place to obtain and acting in accordance with the consent of service users.

The enforcement action we took:
We have issued a Notice of Decision to restrict new admissions to the service.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The provider did not have a system in place to receive and handle complaints.

The enforcement action we took:
We have issued a Notice of Decision to restrict new admissions to the service.

Regulated activity	Regulation
Personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There insufficient staff to provide people with the required care.

The enforcement action we took:
We have issued a Notice of Decision to restrict new admissions to the service.

Regulated activity	Regulation
Personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Staff did not receive appropriate training.

The enforcement action we took:
We have issued a Notice of Decision to restrict new admissions to the service.