Wellbeing Care Limited

Wellbeing Care Support Services

Inspection report

45 Cotmer Road, Lowestoft, Suffolk NR33 9PL
Tel: 01502 572591
Website: www.wellbeing care.co.uk

Date of inspection visit: 2 April 2015
Date of publication: 12/06/2015

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 2 April 2015 and was unannounced.

Our previous inspection of 6 March 2015 had found breaches of a number of regulations. These were how the service looked after the care and welfare of people, assessed and monitored the quality of the service provided, safeguarded people from abuse, managed medicines, obtained people's consent, managed complaints, recruited and supported staff. After the inspection of 6 March 2015 we served the provider with a notice preventing them taking on any new clients.

At this inspection we found these breaches of regulation had not been fully addressed.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Summary of findings

- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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

On the day of this inspection there was not a registered manager in place. The provider had recently appointed a manager who told us it was their intention to register. 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.

This inspection found that the new manager had begun to put in place processes and procedures to deal with the breaches of regulations identified above. However, due to the timescale since our previous inspection these had been fully implemented and as yet were not effective.

Some new care plans had been written but these did not address the support people using this type of service required. The manager was in the process of devising care plans which would fully meet the complex needs of people.

Medication training had been undertaken. However an audit carried out by the inspector found discrepancies in the administration and recording of medication.

The Mental Capacity Act was not being applied. The manager told us they had arranged for the way people were cared for to be reviewed in conjunction with their social worker and other appropriate people and appropriate applications made to the Court of Protection. The reviews had not taken place on the day of our inspection.

Plans to monitor the quality of the service and carry out risk assessments relating to the provision of care were being formulated but were not in place on the day of this inspection.

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 to provide care safely.

Recruitment procedures did not ensure people were safe to work with vulnerable adults before they provided care.

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 support to maintain a healthy diet and have access to healthcare professionals.

Inadequate

Is the service caring?
The service was not consistently caring.

Positive relationships had not been developed with people using the service.

Plans to involve people in decisions relating to their care were in place.

Requires improvement

Is the service responsive?
The service was not responsive.

Care plans did not reflect people's needs.

The provider did not have a system for investigating complaints and responding to any identified failure.

Inadequate

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

People were put at risk because there were no 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.

Robust data and records management systems were not in place.

Inadequate

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 2 April 2015 and was unannounced.

The inspection team consisted of two inspectors.

Before the inspection we reviewed information we held about the provider. This included information from the local authority safeguarding team and our previous inspection of 6 March 2015.

People receiving care were not able to speak with us about the care they received. We spoke with one relative of a person receiving care and support, one member of care staff and the registered manager. Prior to the inspection we had spoken with the director of the provider's company and the local authority safeguarding team.

Inadequate

Is the service safe?

Our findings

Our inspection of 6 March 2015 found that the service was in breach of a number of the regulations of the health and Social care Act 2008 (Regulated Activities) regulations 2010. We foud that people did not have the freedom to come and go as they wished, staffing levels were insufficient to meet peoples needs and medicines were not managed safely.

On 6 March 2015 we found that the service was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This equates to a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the doors to two people's flats were kept locked shut when the person was in the flat and the person did not have the freedom to come and go as they wished. No risk assessments or best interest decisions by those qualified to do so were in place to ensure this was the least restrictive option.

At this inspection, the manager told us that arrangements were in hand to review the care of these two people with the involvement of their social workers, to ensure the least restrictive option was in place and make an application to the Court of Protection if appropriate. They also told us that reviews were planned to take place for everybody being supported by the service with the involvement of the person's social worker. However on the day of this inspection we found that the doors to these flats were still kept locked. No risk assessments or best interest assessments were in place. This meant that people continued to have their freedom restricted without the appropriate measures in pace to ensure people were involved in this decision.

At our inspection on 6 March 2015 we found that risks to individuals were not managed so that people were protected and their freedom of movement supported. Previous safeguarding investigations which had been substantiated showed that people were not supported to access the community safely. At this inspection on 2 April 2015 we found that people's care plans had not been updated with risk assessments relevant to their being supported to access the community by care staff.

This was a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The inspection of 6 March 2015 found there was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This equates to a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staffing levels were not assessed and there were insufficient staff to meet people's assessed needs. Effective recruitment procedures were not in place. Where checks had revealed that a member of staff may be at risk when working with vulnerable adults, no action had been taken to assess or mitigate the risk. Staff had not received training to provide care safely to people with complex needs such as those presenting with distressed reactions to others or their environment or epilepsy.

Prior to this inspection the provider sent us details of the staff rota showing that staffing had been planned to cover people's needs. On the day of our inspection the manager told us that they would continue to plan the rota in advance to ensure that there were sufficient staff on duty to meet

people's needs. Staff training was planned. The manager told us that they had been in contact with the local college to arrange staff training. However, staff supporting people with complex needs, such as as those presenting with distressed reactions to others or their environment had not received appropriate training. We found that a person with epilepsy who was at risk of an episode, was not supported by staff who had undertaken appropriate training to keep this person safe.

This was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our inspection of 6 March 2015 found there was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This equates to a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we were unable to account for medicines and found numerical discrepancies in recording. One person had their medicine not had their medicine as administered prescribed which may have impacted on their health and welfare. The auditing system was ineffective at monitoring and identifying issues arising in relation to the administration of people's medicines. One person was receiving their medicines covertly. There was no best interest decision or risk assessments in place in relation to

Inadequate

Is the service safe?

this. Staff had not received effective training in the administration of medicines and in the case of one medicine prescribed for the urgent treatment of epileptic seizures only one member of staff had received training.

At this inspection on 2 April 2015 the manager told us that staff had received training in the administration of urgent medicine for the treatment of epileptic seizure and training and auditing of medicines was being undertaken by a consultant employed by the provider. We checked one person's medicines and found medicines were hand written on the medication administration record (MAR) and the number of tablets received at the beginning of the cycle had not been recorded. The entry on the MAR chart had not been countersigned. We found that staff had signed for the administration of three tablets which were still present in the packet. Medicines had been secondary dispensed into an envelope which contained four tablets with the name of the medicine written on the envelope but not more details. Therefore, we could not be assured that this person had received their medicines as prescribed or in a safe manner.

.

The provider had failed to take action to respond to our concerns identified at our previous inspection as guidance in the administration of covert medicines had not been followed. There were still no risk assessments, mental capacity assessments or guidance for staff in place. No written guidance had been provided for staff to refer to about the administration of medicines prescribed for as and when required medicines (PRN) administration. This meant we could not be assured people were administered their medicines safely and when appropriate.

This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager was aware of their responsibilities with regard to making safeguarding referrals to the local authority. The local authority is responsible for investigating allegations of this kind. On the day of our inspection we saw they were making a referral about some information they had found since taking up the position.

Inadequate

Is the service effective?

Our findings

Our inspection of 6 March 2015 found that the service was in breach of a number of the regulations of the health and Social care Act 2008 (Regulated Activities) regulations 2010. We found that staff were not appropriately trained and supported to carry out thie roles and that mental capacity assessments had not be carried out in line with current legislation,

At our inspection of 6 March we found that there was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This equates to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not received induction, supervision or training to enable them to carry out the duties relevant to their role.

At this inspection of 2 April 2015 we spoke with the manager about staff training and induction and checked training records. The manager told us that to date the staff had received extra training in the administration of medication. Records we saw confirmed this. They told us they had been in touch with a local college and that they planned for all staff to undertake a sector specific qualification. They also told us that they were planning to undertake staff supervisions and appraisals but to date these had not taken place. However, on the date of this inspection staff had not received appropriate support, training, development supervision and appraisal to enable them to carry out their duties. This meant that people using the service continued to be cared for by staff who did not have the appropriate training to meet their needs.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our inspection of 6 March 2015 found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This equates to a breach of Regulation 11 of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's records did not identify whether or not people had the capacity to make decisions about their everyday lives. Two people had the door to their flat locked whilst receiving 24 hour support. Another person's care plan recorded the use of a handling belt when accessing the community. Care records did not contain any assessment or best interest decisions or mental capacity assessments regarding these actions.

At this inspection we saw that these people's care plans had not been updated with the necessary risk assessments, best interest decisions or mental capacity assessments. We looked at the format of the care plans the provider was proposing to put into place. These care plans did not effectively address the needs of people using this service. They asked such questions as, "Do you like to wear slippers in the evening?" They were not relevant to people living in their own home and did not address the concerns which were raised at the last inspection in relation to risk assessments and individualised care planning..

This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not support all of the eight people with food and drink as some people managed

this themselves. However, one person who did receive support showed us the food they had in their cupboards, fridge and freezer. We asked them how they decided what to eat but they were unable to tell us. There were numerous open packets of food in the freezer and various types of food packets open in the cupboards including cereals. Care records did not record this person's food preferences or show how their meals were planned to meet their nutritional and hydration needs.

Our previous inspection of 6 March 2015 found that people were not supported to maintain good health, have access to healthcare services or receive on going health care support. For example, with regular visits to the dentist, optician and psychiatrist. At this inspection we discussed this with the manager. They agreed that people had previously not been supported with access to healthcare appointments but told us that new care plans would ensure that visits and appointments were recorded. We spoke with one relative of a person who described to us how previous to the managers appointment their relative had not been supported to with visits to healthcare professions. However, they went on to describe how the service had recently supported their relative with a visit to a

Inadequate

Is the service effective?

care professional. The manager told us it was difficult to keep in touch with other health care professionals when the service does not have a dedicated telephone line for other services to contact them.

Requires improvement

Is the service caring?

Our findings

Our inspection of 6 March 2015 found that people were not treated with kindness and compassion. People, or their relatives, were not involved in decisions about their care planning.

At this inspection on 2 April 2015 we visited one person in their flat. They were unable to speak with us but we saw that they were comfortable and relaxed with their carer. The carer addressed them in appropriate terms and asked them what they wanted as they provided care and support. For example, what they would like to drink.

The service was involving people or their representatives in decisions regarding their care as new care plans were being written. We spoke with a relative who told us how they had had an appointment to review their relatives care and that they been involved with risk assessments. The manager told us how they planned to involve people in their care planning and that they were contacting an advocacy service to provide support to people to make decisions.

A relative told us how one person's flat had not been treated with respect and had been dirty on several occasions when they had visited. They told us that when they have visited in recent weeks the flat has been clean and well cared for.

The manager described to us how they would be ensuring that care staff treated people with dignity and respect. They told us that they had already taken disciplinary action against one member of staff and that this subject would be discussed at planned staff meetings.

This inspection found that as yet people did not receive care that was empowering and provided with compassion. However, plans were in place for this to improve but these were not sufficiently advanced for us to improve the rating from our last inspection.

Inadequate

Is the service responsive?

Our findings

Our inspection of 6 March 2015 found that the service was in breach of a number of the regulations of the health and Social care Act 2008 (Regulated Activities) regulations 2010. We found that people's care plans did not reflect their care and support needs and that there was no effective complaints procedure in place.

Our inspection of 6 March 2015 found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This equates to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care plans had not been reviewed and did not reflect how people would like to receive their care and support and did not contain appropriate risk assessments.

At this inspection we found that the care plans had been revised. However, the care plans still did not reflect the needs of the people using the service. They contained references to residents when the service provides care to people as tenants in their own home. Care plans and risk assessments we saw were not relevant to the person. For example one care plan contained reference to a continence assessment where the person had no identified continence needs.

Our inspection of 6 March 2015 had found a risk assessment from 22 October 2013 stating that a person should not be allowed access to certain types of equipment. At this inspection we spoke with the manager about this. They told us that this type of equipment had been removed from the person's flat pending a review meeting with the person's social worker. However, when visiting the flat and the person showing us their kitchen we found this piece of equipment was available. This represented a risk to the person and care staff. We spoke with the manager about this who made immediate arrangements to remove the equipment.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our previous inspection of 6 March found a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This equates to a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was no complaints procedure in place.

On this inspection on 2 April 2015 there was no complaints procedure displayed in the communal areas of the flats or in the manager's office. We asked the manager if there was a complaints procedure in place. They told us there was not. The provider had not put a complaint procedure in place since the last inspection.

This was a continued breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Our inspection of 6 March 2015 found a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This equates to a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because the service did not have systems to assess, monitor and improve the quality of the service and there were no systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.

There was no registered manager in place at the time of our inspection on 6 March 2015. Since our inspection, the provider has appointed a manager for the service. The manager told us it is their intention to apply to the Care Quality Commission to be the registered manager. We asked the manager for a copy of their job description. They told us they did not have a job description. This meant that they may not have a full understanding of their responsibilities with regard to the running of the service.

We discussed with the manager how they intended to promote a positive culture in the service and deliver a service that was personalised, open, inclusive and empowering. They described to us how they would be involving people using the service, who were able, in recruiting new members of staff. They told us they planned to conduct regular staff meetings and were leasing with the local authority to provide training for staff in understanding their roles and responsibilities with regards to whistleblowing and safeguarding. We were reassured by their plans but as yet there had not been time to put these into practice.

We asked the manager what systems were in place to assess, monitor and improve the quality of the service. They told us that these were in preparation and that they planned regular staff supervisions, staff meetings and quality assurance surveys of the residents to monitor the standard of care. However, as yet these were not in place. The only audit that was in place was a medicines audit carried out by an external consultant. This audit was not effective as when we checked medicines we found errors and gaps in records. The provider's arranagements for auditing did not identify the shortfalls we found at this inspection. We could not be assured that people were receiving their medicines as prescribed.

This was a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider had purchased support from a consultancy service with a view to drive improvement in the service. However, we are aware that they have discontinued this support as this consultancy did not have experience in delivering this type of care. They are now in the process of recruiting a person with high level management experience relevant to this service and their other service.

At this inspection we found that the management were not clear on the type of service they were providing. The service is registered with the CQC as a service providing care to people in their own home. It is normal for this type of service to charge for care on an hourly basis. Prior to this inspection we asked the provider for a record of how much care they were contracted to provide to each person. This was provided. However, when we showed this to the manager to check each person was receiving the amount of care they had been assessed as requiring the manager told us this did not match with the care hours that were being provided. Records did not show how much care people should be receiving against how much care they were actually receiving. In some cases it appeared more care was being provided and in other cases less. The service did not have robust records and data management system in place.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Arrangements were not in place to obtain and act in accordance with the consent of service users.

The enforcement action we took:
A Notice of Decision to restrict admissions is in place.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Persons employed by the service did not received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they were employed to perform. Regulation 18(1)(a)

The enforcement action we took:
A Notice of Decision to restrict admissions is in place.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not do all that was reasonably practicable to mitigate risks to service users. Regulation 12(2)(b) The service did not manage medicines safely and properly. Regulation 12(2)(g)

The enforcement action we took:
A Notice of Decision to restrict admissions is in place.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

This section is primarily information for the provider

Enforcement actions

The service did not have an established, effective and accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. Regulation 16(2)

The enforcement action we took:
A Notice of Decision to restrict admissions is in place.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not have systems or processes to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). Reg 17(2)(a)

The enforcement action we took:
A Notice of Decision to restrict admissions is in place.