The Well House

The Well House

Inspection report

Golden Cross
Hailsham
East Sussex
BN27 4AJ

Tel: 01825873389
Website: www.wellhouserespite.co.uk

Date of inspection visit:
06 September 2016
08 September 2016
22 September 2016

Date of publication:
24 October 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected The Well House on the 6th and 8th September. Following the inspection we received some information of concern and as a result we returned for a third day of inspection on 22 September 2016. The Well House provides accommodation for up to 14 people with a learning disability and complex needs. Some people live at The Well House on a permanent basis while others use the service on a rotational basis for short stays of one or more nights. The age range of people living at the home varied between 20 – 70 years old. People require support with personal care, mobility, health, behavioural and communication needs. Accommodation is provided on two floors in the main house and in the garden of the service was a one bedded annex and a four bedded annex. Each annex was purpose built with kitchens and wet rooms.

The service had a 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.

People, relatives and staff spoke highly of the service. One relative told us, "The Well House is wonderful. I can't sing their praises enough." Another relative told us, "I'm very happy with the care my loved one receives." Whilst the feedback from people was positive, we found areas of practice that were not consistently safe, effective or well-led.

Management of medicines was not always safe. People received their medicines correctly, on time and as they wished to have them. However, best practice guidelines regarding storage and documentation of medicines were not being followed. We also found that the date of opening was not recorded on two open liquid medications which meant that people were at risk of receiving expired medicine which can be less effective.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLs) which applies to care homes. One application to restrict people's freedom had been submitted to the appropriate DoLS office. However, there was a risk that people's rights under Article 5 of the Human Rights Act 1998 were contravened as robust systems were not in place to identify if other people were unlawfully deprived of their liberty. Where an application had been made, staff were not aware that this person was subject to a DoLS authorisation and what it meant for the individual.

The principles of the Mental Capacity Act (MCA) were not consistently embedded into practice. Further work was required to clearly demonstrate whether people had consented to their care plan, staff holding their personal allowance, photograph being taken or sharing of information. We have made a recommendation for improvement.

People felt staffing levels were sufficient. One person told us, "There's always someone to talk to." During the course of the inspection, we received intelligence of concern which raised concerns about insufficient

staffing levels. Although people felt staffing levels were sufficient, the provider was unable to demonstrate how staffing levels were based on the individual needs of people. We have asked the provider to make improvements in this area.

Robust systems to monitor the safety and quality of the service were not in place. Governance systems to identify shortfalls were ineffective and complete, detailed and contemporaneous records were not consistently in place. Where risks were identified to people's safety, documentation failed to evidence how those risks were mitigated. The provider's quality assurance system did not identify service shortfalls we found during the inspection, to ensure service improvements were made.

The provider did not routinely submit statutory notifications to the Care Quality Commission, as required. Under the Health and Social Care Act 2008, providers are required by law to submit notifications. We have asked the provider to make improvements in this area.

The principles of the Mental Capacity Act (MCA) were not consistently embedded into practice. Further work was required to clearly demonstrate whether people had consented to their care plan, staff holding their personal allowance, photograph being taken or sharing of information. We have made a recommendation for improvement .

Staff understood the needs of people and care was provided with kindness and compassion. People spoke highly of the care they received and confirmed they received care in a timely manner. Staff members were responsive to people's changing needs. People's health and wellbeing was continually monitored and staff regularly liaised with healthcare professionals for advice and guidance.

Staff were seen smiling and laughing with people and joining in activities in the home. From observing staff interact with people, it was clear staff had spent considerable time with people, getting to know them, gaining an understanding of their personal history and building friendships with them. One relative told us, "I can't praise them enough. It's a wonderful place and all the staff are amazing. We've looked for somewhere like The Well House for so long and I'm so grateful that we have found it."

Staff had received safeguarding training and knew what to do and who to contact if they suspected any abuse. Staff employed by the provider were provided with a full induction and training programme which supported them to meet the needs of people. Appropriate recruitment checks took place before staff started work.

People's privacy and dignity was respected and staff had a caring attitude towards people. People spoke highly of the activities made available. One person told us, "I really enjoy going out and having fish and chips." Staff spoke highly of the management team and commented they enjoyed working at the service. One staff member told us, "I love coming into work every-day." The service had a friendly and homely atmosphere.

During our inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered providers to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The Well House was not consistently safe.

Best practice guidelines were not being followed regarding safe storage and documentation of medicines. The management of liquid medicines was not always safe.

Robust systems were not in place to demonstrate that staffing levels were based on the individual needs of people. Risk management was not consistently safe.

People told us they felt safe living at The Well House. Staff had a firm understanding of what constituted adult abuse and appropriate checks where undertaken to ensure suitable staff were employed to work at the service

Is the service effective?

Requires Improvement

The Well House was not consistently effective.

The Mental Capacity Act 2005 was not consistently being followed and consideration had not been given as to whether people were deprived of their liberty. Staff's understanding of Deprivation of Liberty Safeguards (DoLS) was limited and staff members were unable to confirm who was subject to a Deprivation of Liberty Safeguard and what that meant for the individual person.

People were supported to have a choice of food and drink. However, systems to monitor if people were meeting their daily fluid target were not effective.

Staff received training that was appropriate to their role and responsibilities.

Staff had a good understanding of people's complex support and health needs

Is the service caring?

Good

The Well House was caring. Staff were caring in their approach to people and understood what was important to the people they

supported.

Staff treated people with dignity and respect, and maintained their privacy.

Staff understood each person's choices, and knew how to communicate with people effectively

Is the service responsive?

Good

The Well House was responsive.

People received support from staff members in order to undertake the hobbies and interests that were important to them.

Care plans detailed people's likes, dislikes and daily routines. Staff members had a firm understanding of people's needs and provided care and support in a person centred manner.

A complaints procedure was available and made available to people.

Is the service well-led?

Requires Improvement

The Well House was not consistently well-led.

Statutory notifications were not always submitted to the Care Quality Commission.

Robust systems were not in place for the monitoring, evaluating and assessing the quality of care. Care records failed to demonstrate and evidence the care people received. The provider was unable to demonstrate strategic oversight and governance.

The management team spoke highly of the people they supported and expressed commitment to providing good quality care. The vision and ethos of the service was embedded into practice and staff and people spoke highly of the management team.

The Well House

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 registered providers were 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, 8 and 22 September and was unannounced. This meant the staff and registered provider did not know we would be visiting. The inspection was carried out by two inspectors and a specialist learning disability advisor.

Before our inspection we reviewed the information we held about the home. We considered information we held about the service, which included safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. The registered provider was asked to submit a Provider Information Return (PIR) prior to the inspection, as this was a planned inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The registered provider submitted their PIR within the agreed timescale.

During the inspection we spent time with people who lived at the service. We spent time in the lounge, and people's own rooms when we were invited to do so. We took time to observe how people and staff interacted. Some people were unable to use structured language to communicate verbally with us, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with those that knew people well. We gained the views of staff and spoke with the registered manager, deputy manager and five staff members. We contacted two relatives after the inspection to obtain their views. Their comments have been included in the body of the report.

We reviewed a range of records about people's care and how the service was managed. These included the care records for nine people. We 'pathway tracked' people living at the service. This is when we looked at people's care documentation in depth and obtained their views on how they found living at the home. It is

an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Medicine administration record (MAR) sheets were reviewed, four staff files, support and employment records, policies and procedures, incident reports and records relating to the management of the service.

The last inspection was carried out on 6 March 2014 and no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at The Well House. One person told us, I feel comfortable here and safe." One relative told us, "I always feel safe leaving my loved one in the care of The Well House." Some people were living with complex needs and were not able to tell us if they felt safe living at the home. People were comfortable in the presence of staff. However, despite the positive feedback we received, we identified areas of practice that need improvement.

The management of pain was not consistently safe. Where people were living with reduced mobility, complex healthcare needs and communication difficulties they may not be able to verbalise if they are in pain. For example, one person had a physiotherapist report in place which advised that if they were reluctant to mobilise to check for any pain. They provided a DisDAT (disability distress assessment tool) tool. 'DisDAT is intended to help identify distress cues in people who because of cognitive impairment or physical illness have severely limited communication.' Despite this tool being available, it had not been completed. We asked staff members why it had not been used and staff members were unable to explain why. This posed the risk that the person was subject to pain and steps had not been taken to mitigate and reduce any pain they may be experiencing

The management of medicines was in need of improvement. Medication Administration Records (MAR charts) had been created by the provider rather than being supplied by the dispensing pharmacy. Best practice guidance highlights that printed MAR charts by the dispensing pharmacy are not essential but handwritten MAR charts do pose a risk. Where MAR charts are handwritten, there must be a robust system in place to check that the MAR is correct before use. These records had not been signed by the care staff creating them nor had they been checked and signed by a second person for accuracy against the prescribed instructions. Omissions in recording were found on various MAR charts. For example, one person's MAR chart was not signed on 19 occasions throughout the month of August 2016. Another person's MAR chart was not signed on 13 different occasions throughout the month of August 2016. There was no indication as to whether the medicine had been refused or not given. We asked a member of staff why the MAR charts had not been signed, they were unable to explain why. MAR charts did not consistently record the date medicines were received from the prescribing pharmacy alongside the quantity. Failure to record the date received and stock levels (quantity) meant that any discrepancy or errors in the administration of medicines could be difficult to identify. The provider was also unable to demonstrate that people had safely received their medicines on time.

Medicines can be less effective or harmful if they are out of date. Some liquid medicines have a limited shelf life once they are opened as they can become less effective over time. We saw two liquid mediations where the date of opening was not recorded. The label on the medicine had been peeled off and replaced with the person's name; therefore we were unable to confirm when the medicine was prescribed and whether it was still safe to administer to people. This meant that people were at risk of receiving expired medicine which could be less effective.

Medicines were stored securely and appropriately. However, the medicine cabinet did not have the

temperature recorded. Extreme temperatures (hot and cold) or excessive moisture causes deterioration of medicines and some are more susceptible than others. The management team were therefore unable to provide an assurance that the temperature of the medicines cabinet had not exceeded twenty five degrees as advised in best practice guideline by National Institute for Health and Care Excellence.

Failure to follow best practice guidelines regarding the administration of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) 2014.

Despite the concerns above, people got their medicines as they each person needed them. people were given medicines at the times that suited the person. People either came to the office or staff supported people to take their medicines in their bedroom. We observed two staff members giving out medicines. Staff explained the medicine and how to take it clearly and gently, encouraging and supporting when needed.

People felt there was sufficient numbers of staff on duty. One person told us, "If I need anything, they're always there for me." One staff member told us, "I would say staffing levels are sufficient." We received information of concern that staffing levels were insufficient and placing people at risk. We brought this concern to the attention of the management team and asked them to demonstrate what systematic approach was used to determine staffing levels. They told us, "We look at the rota diary which tells us when people are coming for respite and whether they are funded for 1:1 care. From this, we then determine how many staff members we require. We then submit a breakdown of the 1:1 hours to social services." The management team also commented that they used a local authority dependency matrix to assess people's needs and outcome of that matrix would determine staffing levels. However, the management team were unable to provide evidence of any completed dependency matrixes. Staffing levels usually consisted of five staff in the morning and four in the afternoon. From the daily hand over, we could see that where people required 1:1 care, staff had been allocated and this level of care was provided. However, the provider was unable to show how they assessed the needs of people who didn't require 1:1 and how staffing levels were based on those needs. For example, we calculated on the 1 September 2016 that the service only had two staff members to nine people who didn't require 1:1 care. The management team were unable to demonstrate how they assessed and determined that two staff members to care for nine people was safe.

Staff members were required to provide personal care, along with provision of activities, cooking, giving out medicines and cleaning. However, the provider was unable to demonstrate how these tasks were factored into the assessment of staffing levels. Analysis of weekly rota's demonstrated that staff were working in excess of 50 and 60 hours a week. It is not illegal for staff to work over 48 hours a week. However, staff should sign a European Working Time Directive, confirming they have agreed to work over 48 hours a week. The management team were confident staff had signed these directives, however, were unable to provide evidence of this. Guidance produced by the Health and Safety Executive advises that staff working long hours can experience heightened levels of fatigue. Where staff were working in excess of 50 hours a week, we queried with the management staff how it was assessed that they were safe to work with people with challenging and complex care needs. The management team told us, "We are aware that some people work long hours and often a high number of night shifts in a row. The rota is formulated in advance and staff can put their names down for shifts they want. Where staff put their names down for a lot of shifts, we will talk with them and offer to find cover for some of the shifts so they can have a break. We are aware we need to seek legal advice from our health and safety company in regards to this." Best practice guidance published by the Government highlights that staff have the right to have an 11 hour gap between shifts. We found that this right was not being upheld. For example, we identified that staff could finish the waking night shift at 07.45am and start the afternoon shift at 14.30pm. This meant they only had five hours gap between shifts. We queried how the management team had assessed that staff were safe to work with people with complex care needs after working a ten hour night shift with a five hour break. The management team confirmed they

would explore this.

We recommend that the provider seeks guidance from a reputable source about the determination of staffing levels and follows current guidance and legislation.

On the first day of the inspection, we raised concerns about the cleanliness and levels of hygiene within the home. Walking around the home, we noticed cobwebs throughout the home, spider webs with spiders, residue of leftover food on the floor in the dining room, carpets were dirty and in one person's bathroom, the residue of urine was noticed on the floor. Surfaces were dusty and splash marks were evident on various walls throughout the home. We were informed that the cleaner had been off for one day but staff members were also responsible for day to day cleaning. On the second day of the inspection, the provider had organised a deep clean and two cleaners were present cleaning the whole home. This meant levels of hygiene and cleanliness had improved by the end of the inspection. However, when we returned on the 22 September 2016, standards had not been maintained. For example, the carpet had residue of dirt and food. We brought our concerns to the attention of the management team who confirmed staff would be cleaning shortly.

We recommend that the provider seeks guidance on the implementation of a robust cleaning regime.

The management of risk was not consistently safe. There were risk assessments specific to the needs of people using the service such as moving and handling, diabetes and behaviours that challenge. These assessments identified the hazard and the measures that should be taken to reduce or eliminate the risk. One risk assessment identified that one person could become anxious which placed other people at risk. The control measures included for the person to be removed from the situation and encouraged to spend time alone or engage with an activity they enjoyed to calm down their agitation. However, risks associated with scalding, burning and the management of hot water were not safely assessed or mitigated. The provider had failed to consult nationally recognised guidance, such as the Health and Safety Executive, 'managing the risks from hot water and surfaces in health and social care.' Bathing risk assessments failed to assess whether people's sensitivity to water temperature was impaired; if they would be able to advise if the temperature was too hot, if they would be safe to be left alone in a bathroom with the bath running, or if they are likely to add water if unattended or whether the person would be able to react to hot water.

Weekly water temperature checks took place which demonstrated that water temperatures were reaching 44c. The provider's internal hot water risk assessment recorded that the water within the home was controlled not to exceed 43c. Documentation did not reflect what action was taken when temperatures had reached 44c. We asked staff what the protocol was around checking the temperature of baths before someone gets in. One staff member told us, "We don't check the temperature of the water every time a person has a bath but I always put my elbow in the water to check it isn't too hot." This demonstrated there was a reliance on the internal thermostatic valves to prevent water temperatures from running too high.

For people living with a learning disability and complex care needs, they may not always be able to advise if water temperatures are too hot. However, the provider had not consulted nationally recognised guidance and had not consistently assessed people's risk of scalding and burning in line with any contributing care needs, such as poor skin integrity. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) 2014.

Staff were knowledgeable about how to support people with behaviour which might challenge. One staff member told us, "People can exhibit behaviours which are challenging, such as kicking, hitting and spitting. However, we treat them like any other person. We talk to them, listen to them and find out what's wrong. Get

them to also find their own solution. We also know their triggers and because we know their triggers, we can avoid situations which may cause their behaviour to escalate." Another staff member told us, "One person can hit and spit, but we just tell them it's not acceptable and talk through their actions." Information was available in people's care plans on behaviour that challenges along with the actions required to manage the behaviour. Individual care plans also recorded what may be the trigger for any distress and how to manage that distress. For example, one person's challenging behaviour care plan noted that changes in routine or having to wait could cause distress. Guidance was in place to manage these behaviours which included 'avoid situations which may cause distress and do not make sudden changes of plan.'

There were policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people as much as possible from abuse. Records confirmed staff had received safeguarding training as part of their essential training at induction and that this was refreshed regularly. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. One staff member told us, "I would raise concerns to the manager, if they didn't take action, I would contact CQC and the local authority."

Staff had been recruited through an effective recruitment process that helped ensure they were safe to work with people at risk. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or adults at risk. The provider had obtained proof of identity, employment references and employment histories.

Requires Improvement

Is the service effective?

Our findings

People spoke highly of staff. One person told us, "They've all been lovely to me." One relative told us, "Staff are wonderful." Observations demonstrated that people had positive relationships with the staff that supported them. However, despite the positive feedback we received, we identified areas of practice that need improvement.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Training schedules confirmed staff had received training on the MCA. Staff had some knowledge of the principles of the MCA and gave us examples of how they would follow appropriate procedures in practice. Staff told us they explained the care they were to provide to a person before they gave it and sought to gain their consent. We saw this in practice. One staff member told us, "MCA is about when a person can't make a specific decision themselves." Another staff member told us, "It's about making sure we always gain their consent."

However, the principles of MCA were not embedded into every day practice and the care planning process did not consistently reflect the principles of the MCA. For example, care plans failed to reflect whether the person consented to their care plan, consented to have their photograph taken or to their information being shared. The provider was unable to demonstrate how they considered and assessed people's capacity. People had bed rails in place. Within the MCA, where people's movement is restricted, this could be seen as restraint. Bed rails were implemented for people's safety but do restrict movement. One person had bed rails.. A bed rails risk assessment was in place which reflected whether the bed rails were necessary. The management team informed us that this person would be unable to consent to the bed rails and they were in place for their safety. An assessment of capacity should be undertaken to ascertain if the person could consent to the restriction of their freedom, for example in the use of bed rails. If not, it must be explained why the bed rails were implemented in their best interest and if other options were explored.

Some people required staff support to manage their personal allowance. Systems were in place which recorded how much money staff held and how much was given to the person on a weekly basis or when required. However, it was not consistently clear how decisions were reached for staff to hold people's personal allowance. One staff member told us, "Due to one's person's level of anxiety, it is in their best interest that we hold their personal allowance." However, they were unable to demonstrate that an assessment of capacity had taken place to determine that they lacked capacity and it was in their best interest for staff to manage their personal allowance, or whether the person had consented to this agreement.

From talking to staff and people, we were confident that decisions being made on behalf of people were in their best interest. However, documentation failed to reflect how the provider was working within the principles of the Mental Capacity Act 2005. We have therefore identified this as an area of practice that needs

improvement.

We recommend that the provider considers national guidance on MCA and care planning.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. During the inspection, we were informed that one person was subject to a DoLS. Staff members were unable to recall receiving training on DoLS, despite training records reflecting that staff had received this.

Throughout the inspection, we spent time with staff, asking if they could advise who was subject to a DoLS and what it meant for that individual. Staff members were unaware that one person was subject a DoLS authorisation. Although DoLS authorisations were in place, people's rights were not protected as staff were unaware of who was under a DoLS and what it meant for those individuals.

Robust systems were not in place to identify when a person may be subject to an unlawful deprivation of liberty. In March 2014, changes were made to the Deprivation Liberty Safeguards and what may constitute a deprivation of liberty. These safeguards protect the rights of people by ensuring that any restrictions to their freedom and liberty have been authorised by the local authority, to protect the person from harm. A key pad was in place to enter and exit the home. Some people required staff support when going out and about and staff advised that they would be worried if some people wanted to go out alone. The management team advised that when they had reviews with social services, DoLS would be discussed. We reviewed a sample of social services reviews. The review for one person identified they would be unable to make complex decisions, such as where to live. This person lived at The Well House on a permanent basis. We explored with staff whether they felt they felt this person was subject to continuous supervision and not free to leave. Staff confirmed that due to the small vicinity of the service, they would most likely know where the person would be at all times and would always provide support when the person went out and about.

From our observations we could see that people spent their days within the home as they pleased and staff regularly took people out and about. However, failure to adequately assess if people are unlawfully deprived of their liberty contravenes Article 5 of the Human Rights Act 1998 and is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to have access to healthcare services and maintain good health. Each person had a health care plan which provided detailed information on people's individual health care history and requirements. For people living with diabetes, records demonstrated that they received annual eye tests, input from chiropody and annual health check-ups. The management of diabetes was effective and clear guidance and risk assessments were in place. Regular blood sugar readings were taken before the administration of insulin and guidance was in place confirming what action to take if a person's blood sugar level was above or below a certain level. For those living with diabetes, guidance was available on the signs and symptoms of high and low blood sugar and diabetes training had been provided to all staff members.

People told us they thought the staff supporting them had the right skills and training to assist them. Upon employment with The Well House, all staff members completed the Care Certificate. The care certificate is a set of 15 standards that health and social care workers follow. The care certificate ensured staff that were new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. One person told us, "The staff are genuine and

always willing to help." A programme of essential training was provided to staff to enable them to carry out their role effectively. Staff spoke highly about the training provided and also felt requests for specific training were met. One staff member told us, "During my supervisions, we explore any additional training which is helpful." The training programme was specific to the needs of people they supported. Training included; challenging behaviour, epilepsy and principles of risk assessment. Where support was provided to people with specific care needs, such as PEG feeding, in-house training was provided to staff and the competency of staff's skills and abilities assessed. The management team told us, "Local nurses come in and demonstrate or we access training via the local authority."

Staff received regular supervision meetings with their manager. Staff told us supervision was regular and supportive and they had an opportunity to raise any issues they might have. One staff member told us, "We have regular supervision but in the interim we can always approach management." Documentation confirmed that staff members received supervision every three months.

People spoke highly of the food. One person told us, "The food is nice, you always get an option." Staff confirmed that options were always made available to people and people were asked at every meal time what they would like. There was a weekly menu in the kitchen. Individual dietary requirements were recorded in people's nutritional care plans, such as the need for a soft diet or gluten free diet. Food and fluid charts were completed where people were identified at risk of weight loss and dehydration. Daily fluid targets had been calculated and recorded in people's care plans. For example, one person's daily fluid intake target was 1200mls. Throughout the day, staff recorded what the individual had to drink; however, the total amount was not calculated at the end of the day. For example on the 6th September 2016, we calculated that one person had received 900mls when their target was 1200mls. Staff members told us they would review the person's fluid intake but agreed they were not calculating their daily fluid intake. There was a lack of strategic oversight about how staff monitored and reviewed whether the person had met their daily fluid target and if not, what was done about that.

We recommend that the provider seeks guidance on the management and oversight of fluid intake.

Good

Is the service caring?

Our findings

The atmosphere of the service was relaxed and happy. People were encouraged to treat the service as their own home. People were seen enjoying cups of tea in the lounge in their dressing gowns before getting ready for the day. People spoke highly of the caring nature of staff. One person told us, "They see me as me and not my disability." One relative told us, "I can't sing their praises enough. My loved ones are very happy there."

Interaction between staff and people was caring and supportive. The registered manager commented to one person as they walked into the lounge, "You look lovely today, have you done something different with your hair?" One staff member told us, "We are one big family here, I don't feel like I'm coming into work, working here." From observation and talking with staff we found that staff knew people really well. They showed from their engagement with people that they had a good rapport with them and understood their varied and complex needs. People's care plans included a profile about each person to help staff understand their individual needs.

We observed frequent friendly engagement between people and staff. Staff responded positively and warmly to people and supported them appropriately with confidence. People were seen regularly walking in and out of the office, spending time with staff. One person brought their hair brush into the office and sat down with the staff member styling their hair. People responded to staff with smiles and laughter. Throughout the inspection, we observed staff members hugging people, providing reassurance and enquiring how their day was going and what they would like to do.

Staff supported people in a kind and sensitive way to be as independent as possible. People's level of independence was developing and increasing and staff continually supported them to achieve more. People were encouraged to make day-to-day choices and their independence was promoted and encouraged where appropriate and according to their abilities. During the inspection, a staff member took a couple of people out to the local supermarket. Staff members also told us how people were encouraged to bring their own laundry down and make drinks independently. Upon arrival at the inspection, we were greeted by a person who lived at the service who offered to make us a cup of tea. Without staff support they made us a cup of tea and told us how they were looking forward to going to work later.

Staff communicated well with the people they supported. Staff knelt down beside a person to talk to them or to sit next to people so that they had eye contact. They also respected people's decisions when they did not want to communicate. Staff gave clear explanations to people about the care and support they were being offered in a way that the person could easily understand. Staff listened carefully to people and responded to their requests. Staff used different ways of communicating with people. Some people used non-verbal forms of communication, such as hand gestures. Throughout the inspections, we observed staff members interact with people using various forms of communication. One person made a gesture to a staff member and instantly the staff member recognised the person was asking for a cup of tea. Staff were able to understand people through body language, facial expressions and certain sounds and supported people in a discreet, friendly and reassuring manner. Staff changed their approach to meet people's specific needs so

they changed the ways they communicated to suit different people.

People were supported to maintain the relationships they wanted to have with friends, family and others important to them. One person told us, "Seeing my friends is really important. Staff often take me to the train station or have picked me up from my friend's house." The registered manager told us, "When people come here for respite, we don't want their family sitting at home worrying or anxious; we recognise the impact on them and want to support them as well." Staff told us how relatives and visitors could visit at any time.

For people living at the home on a long term basis, they had their own bedroom. Their bedrooms reflected people's personalities, preferences and choices. They had posters and pictures on the wall. People had equipment like music systems and televisions, so they could spend their time doing what they wanted. All personal care and support was given to people in the privacy of their own rooms. Staff described how they supported people with their personal care, whilst respecting their privacy and dignity. This included explaining to people what they were doing before they carried out each personal care task. Staff knocked quietly on people's doors before they entered their rooms. They introduced themselves and asked if it was alright to come in. Staff supported people to maintain their dignity. After lunch, one person was sensitively supported to change into a clean top. In return this protected and upheld the person's dignity.

Friendships between people had blossomed while living at The Well House. One staff member told us, "We are one big family here and I wouldn't want it any other way." Two people had started making music together and throughout the inspection we observed people spending time together.

Staff were sensitive to the emotional needs of the people they supported. For people with reduced mobility, daily records demonstrated that staff provided hand massages and that their favourite music was playing. Where people sought comfort from soft toys, staff respected that. One person had various soft toys which provided comfort and reassurance. Staff acknowledged the importance those toys played in their life and engaged with the person through the toys. One staff member told us, "They are really important and go everywhere with the person. They have individual names which we all know and we make sure they have them to hand."

Good

Is the service responsive?

Our findings

People told us they were happy with the support they received. One person told us, I'm very happy here." Another person told us, "There are lots of trips and I go to lots of different places." One person's relative told us, "What I like about The Well House is that they appeal to their educational side and my daughter really enjoys helping out in the kitchen." Another relative told us, "I always receive a summary at the end of my loved one's stay at The Well House, advising what they did. They always come back very happy after a weekend at The Well House."

An assessment of people's needs was carried out before moving into the service or receiving respite to make sure their needs could be met. The management told us, "We need to ensure we can meet people's needs and that this is the right environment for them." Before moving in or receiving respite care, people were encouraged to spend the afternoon at the service. This enabled them to spend time with staff and the other residents to ensure The Well House was the right environment for them. The registered manager told us, "Through slowly introducing people to The Well House, we build rapports with them and now many people come back for regular respite."

Staff had a good understanding of the support people needed. Each person had an individual care plan. This was maintained as a tool to enable staff to work with people as individuals. Each care plan included a pen portrait which provided a clear overview of the person's needs, likes, dislikes, their life so far and what they preferred to be called. Care plans also included guidance on daily routines, things that may worry the person, how to make them feel better and how to effectively communicate. For example, one's person's care plan identified that although they had limited verbal speech, they understood what was being said and could indicate yes or no. The information ensured staff supported people appropriately and consistently.

Each person had a key worker assigned to them. One member of staff told us, "I am a key worker for one person. It's about providing that extra care and a being a key person for them and their family. This person I key work is lovely. They really enjoy flower arranging and other various activities." Another staff member told us, "The person I key work has a very rare and complex condition but I really enjoy supporting them." The overall aim of key working is to ensure the provision of holistic care and support to meet the individual needs of the person and their family.

People were at the heart of the service and the management team were dedicated to ensuring the service was 'client run'. The management team told us, "This is very much a client run service. This was echoed in the feedback we received from staff members. One staff member told us, "It's all about the residents, if they want to do something, we'll always try and do it (if possible)." The registered manager told us, "One person wanted to go to London to see a theatre show, so we organised a trip and went to see one. Another person is currently interested in coach trips, so we are looking into organising a coach trip." To accommodate the needs of one specific person with complex and challenging care needs the provider had built a specifically adapted one bedroom unit in the garden of the service so the person's care needs could be met in a person centred environment. The registered manager told us, "It was suggested to us by the local authority and we agreed. We wanted to provide an environment that was suitable and it's worked really well."

Communication was valued within The Well House. Through the forum of handovers, communication books and diaries, staff members were kept up to date with any changes in people's needs. Staff members spoke highly of communication within the service. For those staying for respite care, at the end of each stay, a short summary of care was provided to their relatives/guardians which provided an overview of their stay. Feedback was obtained from relatives and people after each respite stay. Feedback forms were provided in pictorial form which explored whether they liked the food; what they found wasn't so good and how they found the activities. The management team told us, "Any concerns received via feedback we'll act upon, such as updating the care plan and thinking about how we could improve their experience when they next come and stay."

People led varied and active social lives and took part in hobbies and interests that were important to them. Staff members confirmed that people were asked on a daily basis what they would like to do that day. One staff member told us, "We offer a wide range of activities, we have movie nights, go out bowling or to the cinema." Another staff member told us, "We went to the local pub at the weekend, the laughter was unreal. I was even approached by a member of staff to say how lovely it was to see everyone laughing." Another staff member told us, "We went to the woods the other for a bear hunt, it was great. Everyone loved it and the laughter was great. We also take people shopping and up to London for the day. Whatever they want to do." Staff members had a firm understanding of people's hobbies interests and activities that were meaningful to them. One staff member told us, "We have a couple of people who really enjoy flower arranging whereas someone else really enjoys knitting." During the inspection, we observed people engaged with activities they enjoyed. For example one person spent time in the quiet lounge listening to classical music whilst another person was enjoying watching their favourite TV programme. Throughout the day, we regularly heard staff asking people what they would like to do.

The Well House promoted people's engagement and social inclusion with their community. Some people were supported to work in the local community and staff member supported them to get to work on the days they were rotated to work. Other people were engaged with local projects such as farming. The management told us, "If people are interested in local projects, we will support them, whether it be taking them there or providing 1:1 care so they can attend."

A complaints procedure was available to people within the home. This confirmed that the service had systems in place to respond to issues promptly. People were informed of their rights and had easy read information of how to complain or raise a concern if they were unhappy. People told us they felt able to raise concerns. One person told us, "I would talk to the manager or deputy manager if I was ever unhappy." The provider had not received any formal complaints in over a year.

Requires Improvement

Is the service well-led?

Our findings

People told us they were happy living at The Well House. One person told us, "Staff have been very welcoming and there is always someone to talk to." Another person told us, "The manager is very nice." Staff members spoke highly of the management team, commenting that the management team were open, friendly and approachable. One relative told us, "The manager is wonderful. I would definitely recommend The Well House. If I was to rate them out of five stars, I'd give them six." Another relative told us, "The Well House was the best respite home I could find. It's really good."

Whilst all feedback about the management was very positive we found the leadership of the service was not effective in all areas. Robust systems to monitor the safety and quality of the service were not in place. Governance systems to identify shortfalls were ineffective and complete, detailed and contemporaneous records were not consistently in place.

Each person had an individual care plan and risk assessments in place which detailed the level of care and support they required. However, records did not consistently demonstrate and evidence the care people received. For example, one person's nutritional care plan stated that they must be 'offered 'fork mashable' (Texture E) food. When they are ill/refusing food and drink then they should be offered 'Thick Puree' (Texture C) food.' Their food and fluid chart reflected they were often having meals which not did comprise of a soft diet. For example, it was recorded they had roast lamb, steak and kidney pie and chicken, ham and leak hot pot pie. Another person's nutrition care plan identified high risk food that should be avoided or made smaller or softer. However, the person's food and fluid chart reflected that these high risk foods had been served. There was no evidence as to whether these high risk foods were provided in a texture that was appropriate. We asked staff if they could tell us about people's dietary requirements and staff demonstrated a firm understanding of those who required a soft diet and observations demonstrated that a soft diet was provided, however, documentation failed to reflect and evidence that a soft diet was being provided. Failure to maintain accurate and contemporaneous records meant the provider was unable to demonstrate that people were provided with the appropriate dietary requirements to meet their needs.

Where people required support to meet their continence needs, documentation failed to reflect this. For example, one person's care plan identified the need for support every four hours to change their continence pad. However, their daily records demonstrated occasions where they were left for up to nine hours without support to change their continence pad.. We asked the management team if they would expect staff members to record and evidence when they supported a person to change their continence pad. A member of the management team told us, "We would expect staff to record this." Staff members confirmed they supported people to meet their continence needs in line with their care plan, however, documentation failed to record this.

During the course of the inspection, we received information of concern that on occasion's only one staff member would hoist a person. Staff members also raised concerns that it was common for only one staff member to move and transfer people. Failure to safely move and transfer can result in harm to the person and staff members involved. The individual risk assessment for moving and handling recorded that two staff

members were required for a safe transfer. We queried with a member of the management team whether they were aware of these concerns. They confirmed they were not. We therefore looked at how the provider could demonstrate that two staff members always supported this person to move and transfer. Daily notes failed to demonstrate this. We brought these concerns to the attention of the management team and asked them to investigate.

Staff members demonstrated a firm awareness of people's individual care needs and were able to relay the level of care they provided to people. However, care records and documentation failed to consistently demonstrate and evidence the actual care provided to people. This is a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Systems were not in place to monitor or analyse the quality of the service provided. The provider was not completing internal quality assurance checks to assure themselves that they were meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) 2014. Health and safety checks were being undertaken but we were unable to locate any completed audits which related to the quality of the service delivered.. Audits help drive improvement and promote better outcomes for people who live at the home. Medication audits had not been undertaken to promote continuous improvements in medicines management. Improvements that we identified as part of the inspection had not been identified by the provider. An infection control audit had been completed in May 2015, however, the absence of a recent infection control audit meant the shortfalls noted during this inspection regarding cleanliness had not been identified by the provider. We asked a member of the management team to talk us through their quality assurance framework. They told us, "We have health and safety checks and receive input from an external health and safety company. We have staff and resident meetings and gain feedback from people. On a monthly basis, a senior staff member will review the care plan and identify when they are next due for review."

Care plans and risk assessments were reviewed on a regular basis; however, the review consisted of a date indicating a review had taken place. The review failed to reflect whether the care plan/risk assessment remained effective, what was working well and what wasn't working well. The absence of a robust care plan audit meant shortfalls in care planning had not been identified.

Comprehensive audits were not in place to ensure service quality improvements in all areas. Systems were not place to identify where quality or safety of care was being compromised and how the provider responded without delay. This is a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The provider was not consistently notifying the Care Quality Commission of incidents where injury, harm or abuse had occurred to people or events which stop the running of the service. Under the Health and Social Care Act 2008, providers are required by law to submit statutory notifications. A notification is information about important events which the provider is required to tell us about. The provider had notified us some incidences but had not notified us when an authorisation was granted to deprive a person of their liberty. We have asked the provider to make improvements.

The décor of the service required refurbishment. Carpets were stained and discoloured. Curtains around the service were stained and the banisters and doorframes were worn and chipped. The registered manager told us, "We discuss regularly with the director our plans and we have identified the need to redecorate. It is our aim this year to get that done." Although this was not formally documented in a service improvement plan, the provider had identified the need to improve the service and formalise a plan with a timeframe for redecoration.

Despite the above concerns, the management team spoke with pride and compassion and expressed commitment to running a service which was 'resident led.' The registered manager told us, "Our background is in care and after working for social services for many years, we felt we could provide a better level of respite care. We found this home and have been open for over ten years now. We provide respite and permanent care but our overall aim is that people are looked after to the best of our ability and meet their potential." The ethos of the service was embedded into practice and staff spoke highly of the service. One staff member told us, "The closeness of everyone here is what I enjoy. It doesn't feel like I'm coming into work every day. It's all about the residents here."

The governing values of the service were made available to people and staff. Staff told us that a key strength of the service was its homely atmosphere and how the Well House was people's home. It was clear that the management team and staff knew each person well, their likes, personality and dislikes. Staff spent time sitting with people, chatting, watching television and taking people out and about. People looked at ease with staff members and laughter was continually heard throughout the inspection. It was clear the provider and staff had created a home where 'family values' were a philosophy and vision set.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that people were protected from the risk of harm. Regulation 12 (1) The provider had not ensured the proper and safe management of medicines. Regulation (2) (g)

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 The provider had not ensured that service users were not deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 13 (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that there were effective systems to assess and quality assure the service. Regulation (17) (1) (2) (a) The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user. Regulation (2) (c)