Individual Care Services

Individual Care Services - 11 Wembrook Close

Inspection report

11 Wembrook Close
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Warwickshire
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Tel: 01527857280

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 25 November 2016. We gave 48 hours notice that we would be visiting to ensure that people and staff would be available to speak with us.

11 Wembrook Close provides care and accommodation for up to four people with a diagnosis of a learning disability or autistic spectrum disorder. Three
ladies lived at the home at the time of our visit.

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. There was no registered manager in post at the time of our inspection. The provider had appointed a new manager who was going to complete their registration with us.

People were protected from harm and abuse because staff understood their responsibilities to report any concerns they had about people's health and wellbeing. Staffing levels were flexible to ensure there were enough staff to provide effective care. During our visit each person was taken out and staff were able to spend time with people on an individual basis and respond effectively to their needs. Staff supported people in a kind and caring manner and treated them with dignity and respect. People's rights under the Mental Capacity Act were protected by the provider and staff team and their consent to care was sought.

Staff told us the training they received supported them in providing effective care to people, but some training needed to be updated to ensure their skills were kept up to date.

Care plans were individualised and person-centred. They provided staff with information about people's likes and dislikes and how to meet people's needs in a way they preferred. Risks to people's safety and wellbeing had been assessed and planned for. However, improvements were needed to ensure people's care records were consistently reviewed and updated to reflect changes in people's needs and the way risks were managed. A lack of detailed daily records meant we could not be sure people received the care outlined in their care plans.

Medicines were stored and managed safely and people received their medicines as prescribed. However,

referrals to other healthcare professionals had not always been made promptly when a need was identified.

Recent changes in managers and high staff turnover had affected staff morale and impacted on the emotional wellbeing of people who lived in the home. Whilst staff had confidence in the new manager, they did not see them very often because they had managerial commitments in two other homes. The provider was recruiting a team leader to provide day to day leadership at Wembrook Close.

There had been a lack of oversight by the provider during the previous months to identify the issues we found during our inspection visit.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider 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?

Good

The service was safe.

Staff understood how to protect people from abuse and their responsibility to report any concerns about people's wellbeing or safety. There were enough staff to provide the support people required. Risks to people's safety and wellbeing had been assessed and planned for. People received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always receive consistent support to develop their skills and ensure their knowledge was kept up to date. Referrals to other healthcare professionals were not always made in a timely manner. Where possible staff supported people to make their own decisions and choices. People received the food and drink they preferred.

Is the service caring?

Good

The service was caring.

Staff had a caring approach to their interactions with people. Staff took time to understood people's likes and dislikes. People were supported to maintain friendships and relationships that were important to them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were individualised and person- centred, but were not regularly reviewed to ensure they continued to meet people's changing needs. A lack of daily records meant we could not be sure people received the care outlined in their care plans. Staff supported people to follow their interests and hobbies.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Changes in managers and a high turnover of staff had affected staff morale and impacted on the quality of care people received. The provider had not identified some of the issues we found during our visit. The new manager was confident that consistent management and new processes to support staff development would improve the quality of service provided.

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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.

The inspection took place on 25 November 2016 and was announced. We gave the service 48 hours notice that we would be visiting. This was because it was a small service and we needed to be sure that people and staff would be available to speak with us. The inspection was undertaken by one inspector.

As part of our inspection we asked the provider to complete a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The previous registered manager had completed the form shortly after our last inspection visit. Therefore the information was nearly 12 months old and there had been some changes in management of the service.

We reviewed the information we held about the service. We looked at information received from commissioners and the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services paid for by the local authority.

People had limited verbal communication so we spent time observing how they were cared for and how staff interacted with them so we could get a view of the care they received. We were able to have limited conversations with two people. We spoke with three staff, the manager and the standards director.

We reviewed one person's care plans and two people's daily records to see how their support was planned and delivered. We reviewed records of the checks the staff and management team made to assure themselves people received a quality service.

Good

Our findings

One person told us they liked living in the home. When we asked who they would speak to if they felt worried, they responded, "[Name of manager], she is the boss."

Staff understood their responsibilities to protect people from harm. They understood that abuse could take many different forms, including not meeting people's individual needs. One staff member explained that abuse could be, "Not giving the ladies what they want to eat, not giving them a choice or even ignoring them." Staff told us they would follow the provider's policies and procedures and report any concerns to ensure people's safety within the home. Staff told us they would escalate their concerns if they did not feel they had been responded to appropriately. The manager understood their obligations for managing safeguarding concerns and reporting them to the CQC and the local authority.

The manager explained that staffing levels were flexible to ensure there were enough staff to provide effective care. The minimum safe staffing level was two members of care staff and this level was increased depending on people's needs and their plans for each day. For example, when one person attended a day service, only two care staff were required. On the morning of our visit there were three care staff because all three people were at home. We saw that each person was taken out and staff were able to spend time with people on an individual basis and respond effectively to their needs.

Staff told us the manager tried to maintain three care staff on duty at weekends, but because of staff vacancies this was not always possible. However, they felt they were still able to meet people's needs safely. They told us two staff were enough to ensure people were supported with their personal care needs and were enabled to go out into the community on a regular basis. One staff member told us, "It is okay, we can manage." Staff told us there had been a high use of agency staff, but that the manager had recruited new staff which meant staffing levels had improved. A member of staff explained, "There is definitely always two staff on each shift and I would say the last two or three weeks staffing levels have been better."

The provider had a recruitment policy that ensured all the necessary checks were completed before new staff started working unsupervised at Wembrook Close. This included a police check and obtaining references to ensure staff were suitable to work with the people who lived in the home.

We saw that risks to people's safety and wellbeing had been assessed and planned for, and staff demonstrated they understood how to manage people's risks. For example, for one person whose behaviour could have a negative impact on others, the risk assessment provided guidance to staff on how to

support the person and how to manage the risk. However, improvements were needed to ensure people's care records were consistently reviewed and updated to reflect changes in the way their risks were managed. Many of the risk assessments and management plans we looked at had not been reviewed since March 2015, and two people had experienced changes in their health during that period. Regular reviews would ensure the risk of people receiving inconsistent or unsafe care was reduced.

All the people who lived at 11 Wembrook Close required the use of a wheelchair when mobilising around the home. We saw that all corridors, communal rooms, the bathroom and all the bedrooms were spacious enough for people to safely access and move around them in wheelchairs. The provider had considered the varying needs of people and installed suitable equipment that would support staff in meeting the needs of people with limited mobility safely. For example, there were ceiling hoists in all the bedrooms which were regularly checked to ensure they remained safe to use.

Appropriate security measures were in place. People could only access the home if admitted by a member of staff. Visitors to the home completed a visitor's book.

Medicines were stored safely and securely and there were checks in place to ensure they were kept in accordance with manufacturer's instructions and remained effective. However, the cabinet to store medicines that require stricter controls did not meet the requirements of the Misuse of Drugs (Safe Custody) Regulations 1973 as the door was damaged.

Staff told us they received training so they understood their role in ensuring the safe management of medicines within the home. Each person had their own section in the medicine administration folder with a photograph on the front of their records to reduce the chances of medicines being given to the wrong person. Administration records showed that medicines were given to people when required. Guidelines were in place to guide staff on when to give 'as required' medicines to people who could not always tell staff they needed them. This enabled the staff to provide people with consistent care. Medicines were checked twice a day to make sure they were managed safely and people received their prescribed medicines.

Records showed personal emergency evacuation plans (PEEP's) were in place for each person. They gave instructions about the assistance people would need to safely evacuate the building in the event of an emergency. However, the plans were kept in individual care plans which meant they would not be immediately accessible should an emergency occur.

Requires Improvement

Our findings

During our visit we observed staff appeared comfortable and confident when meeting people's needs. Staff told us the training they received supported them in providing effective care to people.

The provider had processes in place to ensure that when staff started work at the home they had clear guidance and training to support them in providing effective care for people. New staff completed an induction to ensure they understood their role and responsibilities. The induction included a week of training in all areas the provider considered essential and a period of working alongside more experienced workers. The induction was centred on the Care Certificate which is a set of minimum standards for care workers to perform their duties and should be covered as part of induction training. However, one staff member told us that although they had started working towards the Care Certificate during their induction, they had not made any further progress towards it. We raised this with the manager who acknowledged that changes in management meant the staff member had not been supported to complete the Care Certificate. They assured us processes were now in place to ensure new staff would get the support they needed to complete it.

The manager had also identified that some training the provider considered essential on an annual basis, had not been completed as required because of staffing issues. For example, the provider expected staff to complete manual handling and safeguarding every year. However, most training had been completed in March 2015 and was over six months overdue for renewal. One staff member told us, "We haven't really had any training for the last year." Whilst the manager was confident that staff practice continued to be safe and effective, they acknowledged that training was a priority and explained, "All staff need to be put through care standards, essential training and service specific training."

Staff monitored people's health, but we could not be sure that referrals to other healthcare professionals were always made in a timely manner. For example, the notes for a staff meeting in June 2016, recorded that one person needed to be referred to the speech and language therapy team for an assessment following a decline in their health. At the time of our inspection in November 2016, the referral had still not been made. The records for another person showed they had been weighed in February 2016. There were no other records to indicate they had been weighed again until October 2016. Within that time they had lost nine kilogrammes in weight. Although we were satisfied that the appropriate healthcare professionals were now involved in that person's care, we could not be assured that the need for the referral had been identified quickly enough to prevent the weight loss continuing.

A healthcare professional involved in the care of the person who had lost weight had asked that a detailed diary be maintained of what the person had eaten and had to drink. We looked at the records. Although the records recorded the food items such as potatoes or custard, they did not record whether the food had been fortified with extra calories as required. This meant it was not possible to gain a fully accurate picture of the number of calories the person had consumed.

Another healthcare professional had reduced a person's medication. The record of their advice was limited. There was no information about any potential physical or mental side effects so staff could provide effective support during the person's withdrawal from their prescribed medicine.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment

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. Care records showed that people who lacked mental capacity had an assessment carried out so that specific decisions made regarding their health and welfare would be made in their best interests. One member of staff said, "Everyone should be seen to have capacity to make their own decisions, but they have had assessments to identify when they can't." Staff told us they supported people to make as many of their own choices as possible and their responsibility to make decisions in people's best interests. During our visit we saw staff sought people's consent before carrying out care tasks.

People can only be deprived of their liberty to 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider had assessed each individual's care and support arrangements and had, on this basis, made DoLS applications for all of the people living at the home. The manager was aware that one of the authorised DoLS was due for renewal and told us they would submit the necessary application as a matter of urgency.

People received the food and drinks they preferred. One person told us they could choose what they wanted to eat. They told us they were able to have their favourite food which was cheese on toast and ravioli. We spoke with staff about one person's specific dietary needs and how they needed their meals to be prepared. They all had a good knowledge of this person's nutritional requirements.

Good

Our findings

People appeared settled in their home and relaxed around the staff members on duty. Staff were kind and supportive to people and people responded positively to them. One staff member told us, "When care staff come in the ladies always seem happy to see them, they seem to have built up good relationships."

We asked the manager how they assured themselves that staff were caring in their roles. They responded, "Working with the staff team you can understand their values. It is important for them to understand people have a right to a life like you and I. It is actually observing them and watching their practice. You can get a lot from how a staff member interacts with a person and the responses they get. The philosophy is that it is not your home staff, it is the service user's home. It is somebody's home, not a workplace."

Care plans documented people's communication needs and how staff should ensure these were met. They also explained what people's different responses meant so staff could respond appropriately. For example, if one person responded negatively when asked if they wanted a drink in the morning, it meant they wanted to be left alone for a bit longer. During our visit we saw staff were able to interpret people's communication styles and behaviours to identify their requests and needs.

Staff knew people's likes and dislikes. One person's care plan recorded that they liked their chair positioned adjacent to the patio window with a table close by. During the afternoon we saw the person sitting in their chair by the window. Small items they had purchased that morning were on a table by the side of their chair so they could enjoy looking at them. A staff member sat with the person talking about what they had bought.

A keyworker system was in place which meant people had named individual workers who knew them especially well. One person pointed to their keyworker and said, "She is my keyworker, she takes me out sometimes. I love [name of keyworker]." It was clear the person and their keyworker had developed a warm working relationship.

Staff understood the importance of treating people with dignity and respect. Although the people who lived at Wembrook Close had complex physical needs, staff told us how they encouraged them to be involved in domestic tasks around the home. One staff member told us, "[Person] folds the washing up sometimes and will make a cake with hand over hand support. [Person] likes to watch but she doesn't want to join in."

People's rooms were personalised to their taste and reflected their interests. For example, all rooms were

decorated differently with colour schemes chosen by the person. One room had sensory items that a member of staff told us the person enjoyed and benefited from when they were having bed rest. This demonstrated that people's preferences were respected and they were involved in decisions about their life and home.

People were offered additional support to help them make important decisions. For example, some people used the services of an advocate to help them with some decisions, for example in respect of their finances. An advocate is a person who supports people to express their opinions and wishes and weigh up the options available to them, to enable them to make a decision.

People were supported to maintain relationships with those closest to them. One person told us how staff regularly took them to visit a friend and also to visit a family member in another home.

Requires Improvement

Our findings

During our visit we found staff were aware of people and responsive in ensuring their needs were attended to.

Care plans were individualised and person- centred. The plan we looked at provided staff with information about the person's needs including; health, social skills, and communication. The care plan contained clearly detailed information about the person's personal backgrounds, preferences, daily routines, what was important to them and their likes and dislikes. They also contained information about what the person was able to do for themselves, and when they required prompting or support. The person sometimes experienced anxieties associated with everyday care tasks. There were detailed protocols for staff to follow when providing care. These protocols supported the person's emotional wellbeing and minimised the risks of behaviours caused by their anxiety.

Although the information in care plans was person centred and gave staff detailed information about how to meet people's needs, we found they were sometimes confusing. For example, in the care plan we looked at there were two protocols for supporting the person to take their medicines. Neither of them was dated so it was unclear which was the most up to date. We also found care plans had not been reviewed for over eighteen months, so we could not be sure they continued to meet people's changing needs.

Each person had a diary which staff were required to complete each day. The diary handed over information that staff could use when assessing people's care needs. The manager told us the diaries contained information about people's day to day activities, trips out and healthcare appointments. They explained, "It is their version of a life story." We looked at two people's daily diaries. For one person, 14 days out of 24 were blank and nothing had been recorded. For another person, on one day staff had recorded '[Person] was in bed most of the morning. Then got up and went out for a walk.' There was no information as to whether the person was unwell or whether it was their choice to stay in bed. Due to the lack of detailed records, we could not be sure people received the care outlined in their care plans.

One person could sometimes exhibit behaviours that could be challenging to others. A psychologist had requested that any incidents of challenging behaviours should be recorded on 'ABC forms'. We found the forms had not been completed consistently and there was limited information about possible causes or triggers. It was not possible to cross-reference the incidents to the daily records to help identify potential triggers, because the daily records were either blank or incomplete. This meant staff could not identify if there were patterns and themes emerging from incidents and therefore identify how to prevent these

incidents from occurring again.

Care plans contained a section which recorded people's future plans. The future plans record in the care plan we looked at had last been completed in March 2015 and was out of date. This meant that people were not being supported to identify and work towards future plans to support their emotional wellbeing.

Staff supported people to follow their interests and hobbies. On the day of our visit all three people went out. One person went to have their hair done and two others went Christmas shopping. One person told us about the gifts they had bought for a family member and said they had also enjoyed having lunch out. Other outings that were planned included a theatre trip, a pantomime and meals out.

A complaints policy was available for people, so they were aware of how to complain if they wished to. There had been no complaints received in the last twelve months. The manager told us that if any complaints were received, they would be managed in line with the provider's complaints policy and procedure.

Requires Improvement

Our findings

At our last inspection we found improvements were required in the management of the home. The registered manager was managing two other services and there was no clear leadership of the service when the registered manager was not there. At this inspection we found action taken by the provider to improve the management of the service had not been successful and further action was required.

In June 2016 the provider had appointed a new manager and subsequently, the registered manager had cancelled their registration with CQC. Unfortunately, the new manager had not successfully completed their probation period which had a negative impact on the service. We were told that several staff had resigned during this period and at one point there were only three permanent staff members left, one of whom was on long term sick leave. There had been a high use of agency staff during this time to maintain staffing levels.

Staff told us the previous few months had been difficult and challenging. Comments included: "Morale was low and it wasn't a very nice place to work" and, "The staffing here went a bit crazy. There was a lot of staff leaving."

Staff also told us there had been a negative impact on the people living in the home. One staff member told us, "When staffing levels dropped it had an effect on them as well as us. [Person] became more challenging and [person] became more distressed and unhappy. You could tell, they looked more sad." Another said, "The atmosphere, it wasn't nice at all, even for the ladies."

The provider had appointed a new manager for the service in September 2016 who had previously worked at the home. The new manager also had responsibility for two other homes and the provider planned for a team leader to provide day to day leadership. The new manager told us, "We plan to have one dedicated person at the top and then a team leader in each home to provide consistency. My role will be making sure the policies are fed through and any changes in legislation are followed up." At the time of our inspection visit there was no team leader in place.

Staff felt more confident now the new manager had been appointed. They told us the manager had already taken action to recruit more staff and some of the staff who had previously left had returned to the home. One staff member explained, "We needed a lot of new staff and [manager] has been working on that." Another told us, "It went down to nothing at one stage because of people leaving. It is picking up now. [Manager] has worked wonders getting new staff in. Things will start improving now [manager] is here and

she has started putting things in place."

Staff told us that although they felt more confident in the new manager, they did not see them very often because of their other managerial commitments. One staff member said, "We don't really see much of her. This is the first I have seen her in two or three weeks. I am aware she is busy and trying to run three homes. We just pull together as a team really." When we asked another member of staff if they saw much of the manager, they responded, "Not a lot because she is running three homes. It is run by the staff really." However, staff told us the manager telephoned the home every day and was contactable if they needed her. One staff member told us, "Last night I did call to ask if I could give [person] paracetamol and she did answer straightaway."

We looked at how accidents and incidents were managed. We found that where accidents and incidents had been recorded, it was not clear what investigation had taken place to identify the cause or to minimise the risks of a re-occurrence. For example, in May one person had a bruise. There was no record of any action taken to investigate the cause. Another person sustained friction burns from their shower sling. There was no record of the action taken to resolve the issue to protect the person's skin. We looked at the records for recording one person's behaviours. We saw several occasions when the level of behaviour towards staff should have been recorded as 'incidents', but staff had not recognised this. This meant there was a lack of analysis of accidents and incidents to identify any trends and ensure appropriate action was taken to keep people and staff safe.

We found there had been a lack of oversight by the provider during the previous months to identify the concerns we identified. For example, care plans and risk assessments had not been reviewed in line with the provider's own policy and procedures. Poor daily records and accident and incident recording meant the provider could not be assured that people had received the care set out in their care plan or that risks to their health and wellbeing were consistently managed. Records did not evidence that prompt action had always been taken when changes in people's health and well-being were identified. Staff had not received up to date training and consistent support to monitor their everyday practice.

This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Governance.

We discussed this with the new manager who acknowledged staff had not received adequate support and the home and people living in it had gone through a difficult and challenging time. The constant change of managers and the high use of agency staff had left the service unstable and they told us they were committed to making improvements. They explained, "Because staff know me they are more confident now I am around and key members of staff have been here a long time. I am going to work with the team to get them back on track and feel valued. We are looking at different ways to motivate the team and develop them." They showed us a new performance management, supervision and appraisal policy that was to be introduced into the service. The manager explained, "It is more in depth and more detailed about staff's future development. There are more specific targets and goals because they were a bit vague before." They were confident that consistent management support and systems to support the training and development of staff, would ensure people received safe and effective care that was responsive to their changing needs.

The new manager told us that auditing systems would now be closely monitored to make sure they were completed correctly and any areas for improvement would be addressed. For example, they showed us accident and incident reports they had completed when they previously worked in the home. They were very detailed and recorded all actions taken to minimise the risks. The manager explained they wanted to

develop similar high standards of recording keeping throughout the home.

The new manager understood their legal responsibilities to inform us of any important events or incidents that occurred within the home.

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 did not always respond appropriately and in good time to support people's changing needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to identify and assess risks to the health and safety of people who use the service were not implemented consistently.