Wellburn Care Homes Limited

Wellburn House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service in May 2017. A breach of legal requirements was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach of Regulation 12, safe care and treatment. We also issued a warning notice to the provider in relation to regulation 17, good governance and gave a date for them to comply with the regulations.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Wellburn House on our website at www.cqc.org.uk

Wellburn House provides residential care for up to 35 people, some of whom are living with dementia. At the time of our inspection there were 34 people living at the service.

The service had a registered manager in post. 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.

The provider had made improvements to their medicines administration and ensured that when people were asleep, staff returned a little later to give them their medicines. Although improvements had been made to address the issues we had found at the last inspection, there were further areas that needed improved and we made a recommendation.

People felt safe and staff understood their roles and responsibilities regarding safeguarding people from avoidable harm or abuse. Risks had been identified in the majority of cases, although we did find two occasions were the records weren't satisfactorily detailed. The registered manager addressed this during the inspection. Accidents and incidents were dealt with appropriately and monitored by the provider to eliminate as much risk as possible. Emergency procedures were in place to support staff, should a crisis situation occur.

We found the service to be clean and tidy. The provider had improved the environment and the safety of the building by completing a programme of refurbishment, which included new doors and windows and updating their five year electrical certificate (which had been an area of concern at the last inspection).

There were enough staff employed and procedures in connection with the employment of new staff continued to be robust and safe recruitment practices were followed.

People were involved in meetings held at the service along with their relatives. The management team

completed a number of audits and checks to ascertain the quality of the service provided and make changes as necessary. We noted some further areas to improve upon and have made a recommendation.

The majority of people and their relatives and staff with whom we spoke, were complimentary about the registered manager and management team. However, we did receive some negative comments.

We have made two recommendations in connection with mattress audits and medicines management.

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 service was not continuously safe.

We could not improve the rating for safe from 'requires improvement', because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

The issues we found with medicines management from the last inspection had improved. We have made another recommendation due to some further issues identified.

The provider had improved the safety of the building and redecorated.

People felt safe and staff understood their safeguarding responsibilities. There were enough staff employed and recruited safely.

Is the service well-led?

Requires Improvement

The service was not continuously well led.

We could not improve the rating for well led from 'requires improvement', because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Audits and checks were completed and had been improved, although we made a recommendation to further improve these. We also discussed with the registered manager the detail which we found lacking in a small number of care records we had reviewed.

The majority of comments received were positive regarding management at the service. However, we did receive some negative comments.

Wellburn House

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Wellburn House on 30 and 31 October 2017. This inspection was done to check that improvements to meet legal requirements planned by the provider after our May 2017 inspection had been made. The team inspected the service against two of the five questions we ask about services: is the service well led and is the service safe? This is because the service was not meeting some legal requirements.

No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in 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 was carried out by one inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed other information we held about the service, including the notifications we had received from the provider, including those in connection with deaths, safeguarding concerns and serious injuries. We also contacted the local authority commissioners and safeguarding teams for the service, the local fire authority and the local Healthwatch. Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services. We used their comments to support our planning of the inspection.

We placed a poster in the reception area of the service to alert visitors to our inspection and invited them to contact us to offer their experiences of the service.

During this inspection we carried out observations using 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 10 people who used the service and six family members/carers. We also spoke with the registered manager, the deputy manager, two team leaders and contacted eight other members of care staff. We also spoke with the provider's representative, the operations manager who visited the service during our inspection. We observed how staff interacted with people and looked at a range of records which included the care records for four of the 34 people who used the service, medicines records for the 34 people and six staff personnel files, health and safety information and other documents related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found the provider was in breach of regulation 12, safe care and treatment. Medicines management was not safe as people had not always received their prescribed medicines because they were asleep. Recording of particular types of medicines had not been fully robust, for example topical applications (e.g. creams or oils for the body) or 'as required medicines'. 'As required medicines are those that are taken when needed, for example for pain relief. Risk assessments were not always in place and fire and electrical safety needed to be improved. The service now met the regulation, although further areas of improvement were required and we have made a further recommendation.

Since the last inspection the provider had completed a programme of refurbishment work. This included redecoration, fitting new windows, installation of new fire exits and fire exit key pads. The key pads automatically activated to open doors if a fire was located, but precluded people from gaining access to outside spaces. This had been an issue found at the last inspection which had now been rectified. At the last inspection, the provider had not ensured that electrical work was satisfactory; a further inspection had been carried out with work rectified and a valid satisfactory electrical work certificates was now in place. We found the service was clean and tidy with no malodours.

The provider had updated their medicines policy since our last inspection to ensure it included full details of what staff should do in certain circumstances. For example, if people refused on more than three occasions in a 28 day period. At the last inspection we found many examples of where staff had not administered people's medicines, for example, when they were asleep. At this inspection we observed staff practice during a medicines administration 'round'. We found that staff returned later to people who were asleep at the first call, to ensure they received their medicines in a timely manner.

Topical medicine application sheets were used in each person's room when the person had this type of medicine prescribed to them. Care staff had completed these sheets appropriately when they had applied applications to people, for example, after bathing or personal care. Once care staff had applied applications to people, senior staff would mark this off on the person's medicine administration record (MAR) for that particular topical medicine. On one occasion we saw staff sign the MAR when the person had not had their 'creams' applied. We checked later that staff had applied the person's cream and signed the relevant topical medicine application sheet, which they had. We brought this to the attention of the registered manager who said she would follow this up.

People's medicines were ordered in a timely way and were available for people to take. We noted that medicines due for disposal were kept in a cupboard within the locked medicines room. The registered manager was in the process of obtaining a tamperproof container to further protect them and store in line with best practice. The medicines trolley and medicines room were secure when not in use.

Out of the people's medicines we checked on the day of the inspection, we noted that a small number had not received their medicines in a timely manner, for example 30 – 60 minutes before food as stated on their medicine administration record (MAR). One person had risen late and had been given their medicines with

their breakfast, when they should have been administered one of their medicines sooner. We brought this to the attention of the registered manager who said this should not have occurred and would look into it.

We recommend the provider review their medicine practice in line with the NICE. NICE is an organisation called The National Institute for Health and Care Excellence. They provide national guidance and advice to improve health and social care.

The operations manager said they were frustrated that we had found some issues with medicines as they had fully reviewed medicines practice since our last inspection. They said, "It is very disappointing."

People told us they thought the service was safe and were content with the care provided. Comments included, "Everyone is lovely here but I just want to go home [person was missing their own home]"; "I get well looked after - all the girls are great"; "Everything is fine we all enjoy ourselves" and "I feel safe here, yes. I have a secure room, and nice staff to look after me." One person told us, "The carers are excellent. I do like it here; it is just the problem with time of medication and the doctor." We later confirmed that there had been some issues with medicines timing, but this had been rectified. We also confirmed that a GP had been called and attended to the person.

One relative said, "I find it safe enough here and I know my husband is being well looked after." Another relative told us, "It is safe and secure, the people are brilliant, such a caring attitude from everyone - nothing is too difficult."

People and their relatives told us there was enough staff in place. Although some said they were busy at times. We looked at staffing on the day and previous staff rotas and found that enough staff were deployed to meet the needs of the people who lived at the service.

Staff understood their safeguarding responsibilities and told us they would report any areas of concern they had. Staff had received training and policies and procedures were in place to support them.

Accidents and incidents were recorded correctly and monitored for any trends forming. This supported the registered manager to address any issues early and helped people to remain as safe as possible. Emergency plans were in place to support staff at the service in the event of an emergency situation arising. Including personal emergency evacuation plans for each person in the building which would be presented to fire crews in the event of a fire at the property.

We checked mattress settings and found that one was difficult to check because the switch was broken. We brought this to the attention of the provider and this was immediately sent off for repair with staff liaising with healthcare professionals to ensure that temporary measures were suitable while this occurred. In regard to another person's mattress, district nurses confirmed that they had set it at the correct setting. Staff at the service had not recorded this information and although they were checking the mattress settings, they had nothing in writing to check it against. We discussed this issue with the registered manager who confirmed this information had now been recorded. We were also able to confirm that neither of these people had any skin damage due to the issues we had found. The provider told us they would review their procedures to ensure this did not happen again.

Recruitment procedures continued to be robust, with employment checks being undertaken to ensure that new staff members were suitable to work with vulnerable people. This included checking potential staff status with the Disclosure and Barring Service (DBS) to ensure that they were not barred from working with this type of vulnerable client group.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection the service was in breach of Regulation 17, good governance. We issued a warning notice. Audits had not identified the areas we had during our inspection, including those in relation to medicines, fire and electrical safety and recording issues. At this inspection the provider had met the warning notice, although there were further areas to improve and we have made a recommendation.

The provider had completed a large refurbishment programme in the service, including replacing windows, fire doors and installing other new equipment to address shortfalls identified and bring the service to suitable standards. People were no longer in danger of falling on unsecure fire escape staircases as special key pads had been fitted in response. Record keeping had been reviewed and additional information had been added to many documents which were in place, including checks on mattresses for example.

Mattress checks were in place and had been updated to include details of the person's weight in order to ensure the equipment was set correctly. The provider had spent time reviewing care records and risk assessments since our last inspection, although we found two which lacked some detail in parts. Staff knew what they had to do to keep people safe and address their needs, although this was not always recorded and had the potential to cause issues to new and less experienced staff. We discussed this with the registered manager and before the end of the inspection, they had sent us updated details.

The concerns we had found with medicines records and their administration of prescribed medicines had improved since the last inspection. For example, policies had been updated and staff ensured they returned to people to administer their medicines if they were asleep and topical medicines application sheets were completed appropriately. However there were a few further issues we found with medicines management which we discussed with the registered manager to gain their assurances and they confirmed this be addressed immediately.

Recordings of healthcare professional visits were logged in the records we viewed, including GP's and district nurses which had not always been completed at the last inspection.

The provider completed a range of audits, including those in connection with infection control, care plans, medicines and falls. When issues had been identified it was not always recorded what action had been taken or when it was completed. However, we checked a number of issues which had been noted, including those in connection with medicines and maintenance and found actions had been taken. The registered manager said they would ensure this was done in future. Some of the audits did not have a space for the name of the person completing or the date completed. The registered manager told us they would update these documents. They said they would review all records to ensure that space was allocated for this information to be entered. We checked the mattress audits completed and found these were in connection with wear and tear and did not check the actual settings.

We recommend the provider further review their mattress audits.

People's comments were mixed about the management of the service. Comments included, "She's [registered manager] okay"; "She is nice enough. Always says hello and asks if everything is ok"; "Nothing ever gets done when you speak to the manager. I usually try and speak to one of the carers" and "I don't really speak much to her, she seems okay, it's the staff mainly."

Relative's comments were mixed about the management and the running of the service. Comments included, "It is brilliant, I can't thank the (registered) manager enough for her kindness to me when I was looking for somewhere for my mother"; "In the few years my mother has been here it is only since the (registered) manager now that the staff turnover has been high. I have seen a lot of changes. We can't go into the dining room and sit with our relatives now"; "To be truthful I am scared of her [registered manager] so I don't want you to say you have spoken to me" and "I regularly see the manager telling staff off for leaving the lounge empty of a carer, but they can't be everywhere at once."

We asked staff about why people's relatives were not allowed to sit in the dining room any longer. One staff member said, "It is a small space in there when residents are all in, so there is sometimes not enough room. Relatives can still have meals, but we prefer that they sit with their relative in the other communal area or their bedrooms, so the other residents have enough space in the dining room."

When we spoke with staff, the majority were positive about the registered manager, describing her as, "supportive" and "a good, caring manager". One said, "I love the work. I am working on my NVQ." Although we did receive some negative comments, including, "She is sometimes dismissive" and "She talks to you like a child sometimes in front of others."

Relatives told us that meeting were held so that issues could be raised and discussed, although not all relatives felt issues raised were addressed as they should have been. One relative told us, "I missed the last one (relatives meeting) but they (provider) did send me the minutes - nothing changes…same actions on, same as previous. For example, the drinks…yes jugs of juice are available in the lounge but the residents won't help themselves… they need encouragement." We monitored the encouragement which staff gave during the inspection to people sitting in communal areas and their bedrooms, and found that people were offered refreshments on a regular basis. The management team completed daily 'walkabouts' of the service and this was used as another tool to gain the views of people and their relatives and check on the quality of the service.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The registered manager had informed CQC of significant events in a timely way by submitting the required notifications. This meant we could check that appropriate action had been taken.