

Balance (Support) CIC Woodbury

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

This inspection took place on 31 January 2016 and was unannounced. At our last inspections on 24 November and 6 December 2015 we found continued breaches of regulations in relation to safe care and treatment, safeguarding and good governance. We served warning notices for these three continued breaches and asked the provider to make the necessary improvements by 18 January 2016. A warning notice is a formal way of saying to the provider that they were not meeting legal requirements and they needed to make improvements by a set date. At the last inspection we found a breach in relation to staffing which was too early for us to follow-up at this inspection. We will review this at our next inspection of the service.

Woodbury provides accommodation and personal care for up to 15 people with a range of learning disabilities, autistic spectrum disorders as well as physical disabilities. On the day of our visit there were 14 people living in the home.

There was no 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 registered manager left in March 2015. The provider has appointed an acting manager whilst they undertook recruitment for a new permanent manager for the home.

We found that the provider had made all the necessary improvements to address the deficits we identified at our last inspection and so had met the requirements of the warning notices.

The provider had improved the way risks to people were managed. They had consulted with relevant healthcare professionals to ensure risks relating to moving and handling and pressure ulcers were assessed and addressed with suitable management plans in place. The provider had identified those people at risk of developing pressure ulcers and referred them for support from the district nurse who visited them regularly. Staff had attended refresher training in moving and handling and the provider had trained one staff to be the service's 'expert' on moving and handling to support staff improve their practice. Training for staff on supporting people at risk from pressure ulcers was arranged for February 2016. The provider carried out checks that a person's pressure relieving mattress was used correctly to reduce their risk of pressure ulcers. In addition the provider had consulted with a healthcare professional to ensure a person's mattress was safe for use with their particular bed rails, so they could continue to use these items of equipment.

The provider had strengthened procedures for staff to record and report any injuries to people such as bruises or other wounds. Management investigated such injuries to check how they occurred and whether they were the result of abuse. Staff had also attended refresher training in safeguarding since we raised concerns at our last inspection.

The provider had improved the way they monitored, assessed and improved the quality of the service as well as record keeping systems.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The provider had taken the required action to improve in relation to safe care and treatment and safeguarding. They had carried out risk assessments in relation to risks to people from pressure ulcers, moving and handling and bed rails. They had consulted with relevant professionals. Staff had received appropriate training to enable them to support people effectively in relation to identified risks. Training was ongoing.

The provider had reviewed processes to record and report injuries to people such as bruises. Investigations were carried out where injuries were observed.

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

Requires Improvement ●

Is the service well-led?

The provider had taken the required action to improve in relation to how they governed the service. Auditing and recording processes had been revised and strengthened. There were comprehensive monthly audits and records were robust and held securely.

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

Requires Improvement ●

Woodbury

Detailed findings

Background to this inspection

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

This inspection took place on 31 January 2016 and was unannounced. It was undertaken by a single inspector.

Before our inspection we reviewed information we held about the service and the provider such as notifications we had received about allegations of abuse. We also contacted the local authority to ask them about their views of the service provided to people.

During the inspection we observed how staff interacted with the people who used the service. We spoke with five people who used the service and four members of care staff including one agency worker. We looked at four people's care records and records relating to the management of the service including quality audits. After the inspection we communicated with the acting manager via e-mail.

Is the service safe?

Our findings

At the last inspection we found a continued breach of regulation in relation to safe care and treatment. The provider did not ensure risks to people were managed appropriately to ensure their safety. This included risks of developing pressure ulcers, from moving and handling and the safe use of bed rails. This was because suitable risk assessment and management plans were not in place for people identified at risk. We served a warning notice and asked the provider to make improvements in relation to safe care and treatment by 18 January 2016.

After the inspection the provider sent as an action plan detailing the action they had taken in response to the concerns we identified. During this inspection we found the provider had taken the action they set out and had met the requirements of the warning notice.

The provider had identified additional people at risk of developing pressure ulcers and referred them to the district nurse for support. The district nurse regularly visited four people to review the risks to them of developing pressure ulcers and had put care plans in place to manage the identified risks which staff were aware of. The provider had reinforced the risks of people developing pressure ulcers to staff at a recent team meeting so they were aware of the action to take to minimise these risks. They had also arranged for refresher training for staff in supporting people at risk of pressure ulcers to be carried out in February 2016.

At our last inspection we identified staff were not ensuring that a person's air mattress was being used effectively to reduce their risk of developing pressure ulcers. This was because it was not set to the appropriate setting for their body weight and staff had been unaware of this. At this inspection our discussions with staff showed they had a good understanding of the appropriate mattress setting and they checked this daily, although these checks were not recorded. We confirmed the mattress was set to the right setting during our inspection.

Since our inspection the provider had referred people with poor mobility and at risk associated with moving and handling, such as those who required a hoist to transfer, to an occupational therapist. The occupational therapist had recently carried out individual risk assessments for these people and produced guidelines for staff to follow. The provider had arranged refresher training in moving and handling for staff and had communicated changes to the ways people were supported through various means. The provider had also trained one member of staff to be a moving and handling facilitator. This staff member was supporting staff to transition to the new guidelines as soon as possible. Staff were aware of the new guidelines for individuals and confirmed they felt more confident in moving and handling people safely after their recent training.

At the last inspection we found the provider did not ensure a person's bed rails were used safely as they were positioned at the same height as the top of their mattress. This meant there was a risk the person could roll over their bed rails onto the floor. The provider had also not carried out risk assessments or put in place management plans regarding the safe use of bed rails for individuals where these were in use. When we raised our concerns at the last inspection the provider made this person safe by temporarily positioning

a crash mat on the floor next to their bed while they sought advice from a healthcare professional. At this inspection we found the provider had obtained a new air mattress for this person which was a suitable height in relation to their bed rails. This meant their bed rails could now be used appropriately to reduce the risks of them rolling onto the floor. After the inspection the acting manager sent us risk assessments for four people regarding the risks to them from their bed rails and they confirmed they were in place for all people who used bed rails. They also confirmed a written check was being put in place for staff to check bedrail safety. In addition they arranged training on bed rail safety for staff in February. They also arranged for the district nurse to check bed rail safety, as well as the safety of other equipment, monthly.

The provider had arranged for a district nurse to regularly review and care for two people who had restricted mobility and were at high risk of pressure ulcers. The district nurse carried out monthly assessments of their risk of developing pressure ulcers, put risk management plans in place and provided the necessary equipment to manage their risks. However, the provider had not assessed the risks to other people of developing pressure ulcers. Many people spent most of their time sitting in wheelchairs and had continence care needs so could have also been at risk. The provider told us they would liaise with their local health care professional contact for guidance on this and would put these risk assessments in place as soon as possible.

At the last inspection we found a continued breach in relation to safeguarding people. While the provider had improved the recording of injuries to people such as bruises, these records were still not reviewed by management and there was not always an investigation into the causes. This meant people were not protected from the risk of abuse because action was not being taken to identify possible abuse and reduce the risks of it reoccurring. We served a warning notice in relation to this and asked the provider to make the necessary improvements by 18 January 2016.

After the inspection the provider wrote to us with their action plan setting out what they had done to improve their processes to keep people safe. At this inspection we found the provider had taken the necessary action to meet the requirements of the warning notice. One person told us, "I feel safe with this lot [the staff] around!" When we asked another person what they would do if they felt unsafe they told us, "I'd tell staff... tell the manager... I feel safe here." The provider had put in place a new system to record and report injuries to people, with the manager being notified as soon as possible. Staff understood this new procedure and the need to report concerns to the manager immediately. Staff had attended safeguarding refresher training in January 2016 and safeguarding continued to be a standing item on the team meeting agenda as well as being discussed in individual supervision where some staff required additional support in this area.

Is the service well-led?

Our findings

At the last inspection we found a repeated breach of regulation in relation to good governance. We found that, while the provider had improved their quality assurance procedures in some areas, they had not identified that some of the concerns we raised previously had yet to be resolved. In addition the provider could not locate many records we requested during our inspection and had to send these to us, after the inspection, via e-mail. These included records relating to health and safety checks and some people's risk assessments in relation to manual handling. These were important records that described the care people needed and any mitigating risks. These might be needed promptly by staff to refer to, to confirm what support people required. We served a warning notice in relation to good governance and asked the provider to make improvements by 18 January 2016.

After the inspection the provider wrote to us setting out how they would meet the requirements of the warning notice and improve their governance of the service. They told us they had reviewed auditing processes to include regular comprehensive inspections of the service. These looked at a greater range of areas in more depth than previously. They had reviewed key documentation such as risk assessments and had set dates to review risk assessments and other care records. They had reviewed their filing systems to enable documents to be located easily so they could identify and resolve any gaps in required documentation. They also planned to create a 'mapping document' to identify where key documents were stored in the home to aid auditing and governance.

At this inspection we found the provider had taken the action they specified in their action plan and were meeting the requirements of the warning notice. This meant their quality assurance procedures were more effective in protecting people from the risks of unsafe or inappropriate care.