Akari Care Limited

Wellburn House

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**

Overall summary

We carried out an unannounced comprehensive inspection on 15 July 2015 and found the service to be overall Requires Improvement. We received an action plan which stated that the service would be fully compliant by 31 December 2015. After that inspection we received concerns in relation to people who used the service being woken up at five in the morning, being short staffed and one night only three staff members on duty, insulin not being administered, staff not using correct moving and handling techniques, falls not being documented and safe recruitment procedures not being adhered to.These safeguarding concerns have been reported to the local authority. The local authority will manage safeguarding concerns raised in line with their lead role and safeguarding procedures. We undertook a focused inspection to look into concerns raised. This report only covers our findings in relation to this topic. 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. During this inspection we did not check whether the service were meeting these regulations as the registered provider's timescales were not yet reached. But evidence showed reg 12 (1) needed further work to be completed in order for this to be met.

Wellburn House is a 90 bedded purpose built two storey care home. It has two units; the ground floor unit for people with personal care needs and the first floor unit for people with dementia. All bedrooms have ensuite facilities and there is the availability of a large courtyard garden. One section of the building was not currently in use by people using the service with none of the bedrooms occupied or bathrooms used. At the time of this inspection there were 61 people living at Wellburn House.

The home had a manager who had only been at Wellburn House for four weeks. The manager was in the process of completing their application to apply to be registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

We arrived at the service at five thirty am. On arrival it was difficult to gain how many people were living at the service. The senior carer working downstairs did not know how many people were living upstairs and vice versa. Staff we spoke with were not able to tell us fully about the emergency evacuation procedures or where this information was kept. Personal Emergency Evacuation Plans (PEEPs) did not reflect the current information on who lived at the service and what room they occupied.

We did see some people were up and dressed at five thirty am but staff could provide good explanations of why each person was up. The people we spoke with confirmed that it had been their choice to get up. We also saw that the majority of people were still in bed asleep. Therefore we could not evidence that people were being awoken at five am.

We found that once people were up and out of their room, their room would be locked. Staff we spoke with said this was on request of families to stop other people entering their rooms. We saw no documented evidence of this. We were told that people could lock their rooms themselves from the inside and staff had a master key if they needed to enter in an emergency. The night shift staff only had one master key for the whole service and if an emergency did take place this meant they would have to search for the person who was holding that key. We were also told this master key was the same key for the treatment room where medicines were stored.

We looked at the records for insulin administration. Insulin is not administered by care staff in the service but by the district nurse and this was documented.

At the time of our inspection there were enough staff on duty. However staff we spoke with said that they had been short staffed on a number of occasions. We looked at the night when we were told by the person raising the concern there were only three staff on duty. We found that there was six staff on duty that night. We found this information on the staff rotas, staff signing in sheets and payroll information. We did see evidence that on some days they were working with two staff down. The manager said they were aware of this and a recruitment drive was taking place and they were awaiting Disclosure and Barring Service (DBS) returns for some people who had been offered positions. DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults.

A concern was raised regarding the recruitment of staff. We were told that one person had worked before the return of the DBS and staff were not shadowing experienced staff and were working alone. We looked at the recruitment files for five staff who had been recently recruited. One of these was for the person who had worked a shift before the return of the DBS. We saw that the DBS was returned on the 11 November 2015 and this person worked on the 16 November 2015..

Concerns were raised about falls not being documented especially one particular fall. We saw evidence that falls were documented and the particular fall had been recorded correctly with follow up actions taken.

We did note that staff were applying dressings without checking with the community matron or GP that this was the correct one needed for a particular sore or injury. This meant that staff were dressing wounds without any oversight or authority to do so. The residential staff were not trained to determine how best to deliver wound care. This meant that the role of the district nurse was being undertaken by residential staff and this could put people at risk of inappropriate treatment. Also we found that staff continued to store dressings prescribed by the community nurses in people's bedrooms long after their involvement with this service had ceased. We found that some of the items stored were out of date.

Concerns were also raised about moving and handling techniques. We observed people being hoisted and using stand aids. We saw that this was all carried out correctly.

At the July 2015 inspection we found there were breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of that report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

There were not always sufficient staff to meet the needs of the people.

Effective recruitment procedures were in place. Appropriate checks were undertaken before staff started work.

The key to the medicine room was part of the master system.

Personal emergency evacuation plans were not updated to reflect current needs

Requires improvement

Wellburn 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 provider was 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.

We undertook an unannounced focused inspection of Wellburn House on 24 November 2015. We had received concerns in relation to people who used the service being woken up at five in the morning, being short staffed and one night only three staff members on duty, insulin not being administered, staff not using correct moving and handling techniques, falls not being documented and safe recruitment procedures not being adhered to. The local authority will manage safeguarding concerns raised in line with their lead role and safeguarding procedures.

The inspection team consisted of three adult social care inspectors and one specialist professional advisor. A specialist professional advisor is someone who has a specialism in the service being inspected such as elderly care.

Before we visited the home we checked the information we held about this location and the service provider. For example, inspection history, safeguarding notifications and complaints.

During our inspection we spoke with nine people who used the service and three family members. We also spoke with the regional manager, the manager, the office administrator and the receptionist. We also spoke with one external healthcare professional prior to the visit.

We undertook general observations and reviewed relevant records. These included four people's care records, five staff files and staff rotas, staff sign in sheets and payroll sheets. We looked around the home and saw some people's bedrooms, bathrooms, the kitchen and communal areas.

Requires improvement

Is the service safe?

Our findings

We received concerns that people who used the service were being woken up at five am. We arrived at the service at five thirty am. We did see some people were up and dressed at five thirty am but staff could provide good explanations of why each person was up. We also saw that the majority of people were still in bed asleep. Therefore we could not evidence that people were been awoken at five am.

On arrival it was difficult to gain how many people were living at the service. The senior carer working downstairs did not know how many people were living upstairs and vice versa. Staff we spoke with were not able to tell us fully about what the emergency evacuation procedures were or where this information was kept. Personal Emergency Evacuation Plans (PEEPs) did not reflect the current information on who lived at the service and what room they occupied. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. This meant that in the event of an emergency staff would not be sure everyone living at the service was accounted for or that correct procedures would be put in place as up to date plans were not in place to guide staff if there was an emergency.

We found that once people were up and out of their room, their room would be locked. Staff we spoke with said this was on request of families, to stop other people entering their rooms. We looked in the care plan for one person who had their room locked and saw no documented evidence of this. We were told that people could lock their rooms themselves from the inside and staff had a master key if they needed to enter in an emergency. Unfortunately the night shift staff only had one master key for the whole service and if an emergency did take place they would have to search for the person who was holding that key. We were also told this master key was the same key for the treatment room where medicines were stored. This goes against advice from the Royal Pharmaceutical Society, The Handling of Medicines in Social Care, which states: Key security is an important part of medicines security therefore only authorised members of staff should have access to them. The keys for the medicine area or cupboard should not be part of the master system. The manager was not aware of the master key being the same as the treatment room key and was going to look into it.

Another concern raised was that insulin was not being administered. We looked at the records for insulin administration. Insulin is not administered by care staff in the service but by the district nurse and this was documented. Therefore we could evidence no issues with insulin administration.

We did see one person who used the service had a wound to their leg which was undressed. A member of care staff was unsure if the district nurse was involved in the care of this person and spoke to the deputy manager to see if they should apply a dressing. We were told dressings were in the person's room, a new dressing was applied. This meant that residential staff who were not trained to deliver wound care were undertaking this role without the direct instruction of the community nurse. We found that staff continued to store dressings prescribed by the community nurses in people's bedrooms long after their involvement with this service had ceased. We looked at the box of dressings in the person's room and found there to be a mixture of different dressings one of which were labelled for another person and out of date. We discussed this with a visiting registered health professional who said that they were unaware of this wound or that a dressing had been applied that morning and stated "This was unusual when I am in the building". However in general they did acknowledge that they are 'very good at communicating normally.' We discussed the box of dressing with the manager who said they would remove them straight away and arrange for the district nurse to look at the wound.

At the time of our inspection there were six staff on duty. However staff we spoke with said that they had been short staffed on a number of occasions. We looked at the night where a concern was raised and we were told only three staff were on duty. We found that there was six staff on duty that night. We found this information on the staff rotas and corroborated it with staff signing in sheets and payroll information. We did find the rotas very had to distinguish who was on duty when and we asked the manager to provide a more simplified version. This was provided and we did see evidence that on some days they were not working within the boundaries of their own staff dependency tool. For example for night shift their

Is the service safe?

dependency tool stated that they needed one member of staff per 10 people who used the service. This would mean six members of staff were needed but some nights showed five members of staff. The manager said they were aware of this and a recruitment drive is taking place and they were awaiting Disclosure and Barring Service (DBS) returns for some people who had been offered positions. DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults. Staff we spoke with said, "Staffing levels are fine now, but a few weeks ago we were running short." Another staff member said, "Staff levels have been short but they are improving." And "It can be difficult when we have hospital appointments as this takes one member of staff away for most of the day." We asked the relatives we spoke with if they thought there were enough staff on duty. They said, "Would you ever think there was enough staff on duty? They are not always immediately visible you have to look." Another relative said, "They have been very good and understanding with us, my mum is safe she is supervised here."

A concern was raised regarding the recruitment of staff. We were told that one person had worked before the return of the DBS and staff were not shadowing experienced staff and working alone. We looked at the recruitment files for five staff who had been recently recruited. One of these was for the person who had worked a shift before the return of the DBS. We saw that the DBS was returned on the 11 November 2015 and this person worked on the 16 November 2015. This meant that checks had taken place before people started working at the service. One persons file we looked at did not contain a reference from the previous employer. We discussed this with the manager who requested this on the day of inspection and we were provided with evidence of this when it was returned.

We were told that staff completed one day of induction which included policies and procedures, tour of the building, security and safety, privacy and dignity etc. We were also told that staff do three shadow shifts as part of their induction. Although we were unable to confirm if this was the case for all five staff as duty rotas were difficult to understand, staff did confirm this to be the case. We asked if new staff who were shadowing were not all on the same shift and the manager and staff confirmed that new staff were shared out between upstairs and downstairs. This meant that shifts did not consist of all new staff.

Concerns were raised about falls not being documented especially one particular fall. We saw evidence that falls were documented and the particular fall had been recorded correctly with follow up actions taken.

Concerns were also raised about moving and handling techniques. We observed people being hoisted and using stand aids. We saw that this was all carried out correctly. However we did see one member of staff about to 'drag lift' a person but stopped themselves from doing this. We discussed this with the manager who said they would arrange refresher training for all staff.

Another concern was a lot of the toilets in the service were not working and the service smells. We observed one toilet was out of action during our inspection but other toilets were all working fine. We did not experience any unpleasant smells. Relatives we spoke with said, "Her room is always clean when we come in." And "The home is always clean and tidy and free from unpleasant odours. "

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 People may have been at risk of receiving incorrect nutritional intake due to lack of up to date records in the kitchen.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment All premises and equipment used by the service provider must be clean. The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Consent must be sought before any care or treatment is provided.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance We saw that care plan audits were varied in quality, other audits were not in place or were incomplete. Surveys on the views of people were also lacking.

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 People were deprived of their liberty without lawful authority.