Wilbraham Limited

Wilbraham House

Inspection report

Church Street
Audley
Stoke On Trent
Staffordshire
ST7 8DE

Tel: 01782720729

Date of inspection visit:
08 February 2017

Date of publication:
10 March 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We completed an unannounced inspection at Wilbraham House on 8 February 2017. At the last inspection on 16 September 2016 we found breaches of the regulations. After the last inspection, the provider wrote to us to say what they would do to meet the legal requirements. 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 Wilbraham House on our website at www.cqc.org.uk.

As a result of our last inspection, this provider was placed into special measures by CQC. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

Wilbraham House are registered to provide accommodation with personal care for up to 33 people. People who use the service may have physical disabilities and/or mental health needs such as dementia. At the time of the inspection the service supported 29 people.

There was a registered manager at the service. 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.

At this inspection we identified a new 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.

When people did not have the ability to make decisions about their care, the legal requirements of the Mental Capacity Act 2005 were not always followed. We were unable to ascertain if people had capacity to make certain decisions and if people were unable to consent we could not always be assured decisions were made in their best interests.

We found that improvements had been made to the number of staff available at the service. However, we found that further improvements were needed to ensure staff were deployed across the service.

The provider had made improvements to the systems in place to assess, monitor and improve the quality of care. However, some further improvements were needed to ensure all areas of care were assessed and monitored to mitigate potential risks to people.

Records were stored safely to protect people's confidential information. Some improvements were needed to ensure all records contained detailed and up to date guidance for staff to follow.

Risks to people's health and wellbeing were identified, managed and followed by staff safely.

Improvements had been made to the systems in place to monitor accidents and action had been taken by the registered manager to reduce the risks of further occurrences.

People were supported with their nutritional needs and monitoring was in place to ensure people ate and drank sufficient amounts.

Advice was sought from health and social care professionals when people were unwell. We found that this advice had been documented and was being followed by staff to maintain and support people's physical and emotional wellbeing.

People were protected from the risks of abuse because staff understood how to recognise and report possible abuse.

We found that medicines were administered and managed in a way that protected people from the risk of harm.

The provider followed safe recruitment practices to ensure that people were supported by sufficiently trained staff that were of a suitable character to provide support to vulnerable people.

People and staff told us that the registered manager and provider were approachable and staff felt supported to carry out their role.

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

We found that action had been taken to improve safety. However some further improvements were still needed.

Improvements were needed to ensure staff were deployed effectively across the service to ensure people received care at a time when they needed it.

People's risk were managed because staff knew people well and understood how they needed to protect people from possible harm. However, improvements were needed to ensure records reflected what staff told us.

Medicines were administered and managed safely to protect people from the risk of harm.

Staff understood how to protect people from abuse and their responsibilities to report potential abuse.

Is the service effective?

Requires Improvement

We found that action had been taken to improve the effectiveness of the service. However some further improvements were still needed.

We found that people were not always supported in line with the Mental Capacity Act 2005, because assessments carried out were not clear and we could not be assured decisions were made in people's best interests.

Staff had received up to date training to ensure that they had the skills and knowledge to carry out support to people effectively.

People were not supported effectively with their nutritional risks and advice sought from health professionals was followed to ensure people received effective care.

Is the service well-led?

Requires Improvement

We found that action had been taken to improve how the service was led and managed. However some further improvements were still needed.

The provider had implemented some systems to assess, monitor and improve the quality of care. However, we found further improvements were needed to ensure all areas of care were consistently monitored to mitigate risks to people who used the service.

We found that records were stored securely. However, we found that improvements were needed to ensure records contained sufficient information.

People and staff felt that the registered manager was approachable and suggestions made were acted on.

The provider had acted on concerns raised and had implemented an improvement plan to ensure action was taken to improve the quality of the service.

Wilbraham 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 Wilbraham house on 8 February 2017. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our 16 September 2016 inspection had been made. The team inspected the service against three of the five questions we ask about services: Is the service safe? Is the service effective? Is the service well led? This is because the service was not meeting some legal requirements

The inspection team consisted of one inspector, an inspection manager and an 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.

Before the inspection, we reviewed information we held about the service. This included notifications about events that had happened at the service, which the provider was required to send us by law. For example, serious injuries, safeguarding concerns and deaths that had occurred at the service. We also gained feedback about the service from local authority commissioners.

We spoke with seven people who used the service, three relatives, four staff, the registered manager and the provider. We observed how staff supported people throughout the day and how staff interacted with people who used the service. 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 viewed six records about people's care and people's medicine records. We also viewed records that showed how the service was managed, which included quality assurance records, seven staff recruitment and training records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, we found that there were insufficient staff available to meet people's needs and to keep people safe from harm. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that improvements had been made. However, some further improvements were needed.

We received mixed feedback from people and relatives we spoke with about the staffing levels at the service. One person said, "I am looked after fine, but there is not really enough staff here". Another person said, "There are not always enough staff, especially after tea. Staff don't come in here often to check you. I feel they're understaffed". A relative said, "There have been improved staffing levels and I've noticed buzzers being answered more promptly and improvements have been made when people need the toilet". Another relative said, "I feel there is enough staff, they always stop to chat when we are visiting. We usually visit in a morning and it's always busy".

Staff told us that there had been improvements in the staffing levels and there were enough staff available to meet people's needs. We observed staff supported people with their needs in a timely way and call bells were answered quickly. However, we saw that there was not always a staff presence within the lounge areas at different times during the day and people who were unable to use their call bells were not always heard. For example; one person called out for staff and there were no staff in the lounge at this time and they were not heard. This person settled quickly and did not require assistance, but staff were not available in the area when the person called for them. Staff told us that there were no set areas for staff to monitor and they worked across the service. We discussed our concerns regarding the deployment of staff around the service with the registered manager and provider. The registered manager and the provider told us they would look into the issues raised and the way they deploy the staff across the service. This meant that some improvements were needed to ensure staff were deployed appropriately across the service to ensure staff were available when people needed them.

At our last inspection, we found that there were risks to people's safety and welfare because people's risks were not always planned and managed to keep people safe and medicines were not managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that improvements had been made and they were now meeting the requirements of this regulation.

We found people were supported in a safe way. People we spoke with told us staff supported them to move safely and they felt safe when staff helped them. One person said, "Staff help me to move from my chair to a wheelchair and I feel very safe when they help me. They know what they are doing". Staff explained people's risks and had a good understanding of how they needed to support people to remain safe from harm. However, although staff knew how to support people with their risks the records we viewed did not always match what staff had told us. For example; we saw that one person displayed behaviours that challenged. Staff we spoke with explained how they supported this person when they became anxious or agitated. However, the records we looked at did not give staff guidance on how this person's risks needed to be

managed consistently to keep them safe. This meant that this person was at risk of inconsistent and unsafe care, because records were not up to date and further improvements were needed to ensure that records contained sufficient information.

As the last inspection we found environmental risks to people had not been considered. For example; risk assessments were not in place to give staff guidance on how to keep people safe when they were in the area of the stairs. At this inspection, we found that a risk assessment had been completed and a gate had been erected at the bottom of the stairs to ensure people who were at risk could move around the service freely but were also protected from the risks associated with them using the stairs. This meant that people were protected from the risk of harm because environmental risks had been assessed and managed to keep people safe.

We found that improvements had been made to the way medicines were administered and managed. People told us they were supported to take their medicines by staff. One person said, "They [staff] give me my tablets in the morning, at lunchtime and night time – I rattle". We observed staff administered medicine in a safe and dignified way. The staff member who was administering medicines explained to people why they needed to take their medicines and ensured that people had taken their medicines. We found that medicines were stored securely in a locked trolley and when not in use this trolley was stored in a locked medicine room. Where people needed 'as required' medicines; such as pain relief we saw that protocols were in place to give staff guidance on when these medicines were required. The provider had changed the medicine system since our last inspection to an electronic system, which recorded people's medicines and also keeps a record of the stock of medicines available. Staff told us that this new system had been a big improvement and it also saved time when administering medicines. We carried out a check of the amount of medicines in stock against the records and found that the correct amount of stock was available. This meant that medicines were administered and managed in a safe way.

We found that people were protected from the risk of abuse because staff we spoke with understood how to recognise and report abuse. One staff member said, "I would report any concerns to the manager and have done in the past. We also make sure we monitor people if we feel there are concerns". We saw that staff had reported incidents to the registered manager, who had taken action to ensure people were protected from the risk of abuse. The registered manager had a good understanding of their responsibilities to protect people from abuse and had reported incidents of abuse to the local authority for investigation.

Requires Improvement

Is the service effective?

Our findings

We found that the requirements of the Mental Capacity Act 2005 (MCA) were not followed appropriately. The Mental Capacity Act 2005 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. Staff we spoke with had some understanding of the MCA and how they needed to support people with decisions about their care. However, we saw that the mental capacity assessments that had been carried out were not detailed and did not give a clear view of people's ability to make informed decisions. For example; one person's assessment stated that they did not have capacity, but it was not clear if this person had the ability to make some day to day decisions and how staff needed to support this person to make decisions. Another person's mental capacity assessment stated that they were unable to make decisions about their care and their relatives would make these decisions for them. There were no legal documents available to show that relatives making these decisions were the authorised representatives to make decisions in this person's best interests. We spoke with a visiting health professional who told us that they were unable to identify from the care records if people had capacity to consent to their treatment. This meant that people were at risk of receiving care that was not in their best interests.

We spoke with the registered manager about their understanding of the MCA and found that they were aware of how capacity can affect people's ability to make decisions. However, they were not fully aware of their responsibilities under the Act. They said, "I see what you mean. I need to put more information down and make sure we have all the details. I will look at this straight away as I agree we haven't always done this. I will update my knowledge in this area too". This meant that the registered manager was not fully aware of their responsibilities in line with the requirements of the act, which put people at risk of inappropriate care.

This meant that people who were unable to consent to their care were at risk of receiving care that was not in their best interests because the provider had not acted in line with the Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found staff were not always sufficiently trained and competent to provide safe and effective care to people. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that improvements had been made.

Staff told us they had received training to carry out their role effectively. One member of staff said, "I received training when I started and I have recently had training to refresh my knowledge, which was good". We saw that people were supported effectively in line with best practice. For example, we saw that people who needed support from staff to move were supported following safe handling procedures. We were told by the registered manager and we saw that there was a schedule in place which ensured staff had up to date training to meet people's needs. This meant that staff had received training to carry out support to people in a safe and effective way.

At our last inspection, we found that people were not supported to maintain their nutritional needs. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that improvements had been made.

People were happy with the quality of the food and comments we received included; "If I want a hot drink anytime there is a flask of hot water on the side in the dining room with tea and coffee. The food is good, there is always a choice. I am gluten intolerant and the staff know my dietary needs" and "The food suits me because there is not too much meat but we get different choices. There is plenty to eat, you can specify, a small, medium or large portion". However, we saw that some people had to wait long periods of time for their meals at lunch and were asking where there meals were and people who were unable to help themselves to drinks waited long periods until they were offered another drink. One person told us, "It's always like this and we are always the last to be served". This meant that some improvements were needed to the way mealtimes were managed.

People were supported effectively with their nutritional needs. We saw that where people had lost weight, actions had been taken to lower the risk of malnutrition for these people. There had been updates in their risk assessments and care plans to give guidance for staff on how to ensure these people received sufficient amounts to eat and drink. Staff we spoke with were aware of people's dietary needs and we saw that staff supported people in line with their plans of care. People who had poor appetites had food and fluid charts in place to ensure that these people's nutritional intake was monitored and managed to prevent further weight loss. This meant that people were supported with their nutritional needs and staff ensured people had sufficient amounts to eat and drink.

People told us that they were able to access health professionals when they needed to, such as doctors, chiropodists and opticians. We saw that where people had lost weight this had been identified and there had been referrals made to the G.P or a dietician for advice to manage people's nutritional needs. For example; we saw that one person had received advice from a physiotherapist on their mobility. The physiotherapist had advised that the person needed prompting to use their walking aid and we saw that staff prompted person to keep them safe from harm. This meant that advice had been sought from other professionals and followed to maintain people's health, safety and wellbeing.

We saw that the registered manager had made referrals for a Deprivation of Liberty Safeguards (DoLS), where they felt people had restrictions in place to keep them safe. 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff were aware of the restrictions in place and we saw staff support the people to keep them safe from harm in line with their individual DoLS authorisations.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, we found that there were not effective systems in place to monitor, manage and mitigate risks to people and protect them from harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that improvements had been made and the provider was meeting the requirements of this regulation, but further improvements were needed to ensure that all areas of the service were consistently monitored.

We found that improvements had been made to the systems in place to monitor the quality of the service provided. For example; we saw the registered manager had implemented daily audits that were carried out by senior care staff in a daily basis to ensure that people received the care they needed. We also saw that systems to check people's weights and food and drink intake were in place. These included a detailed account of the actions recorded if there were concerns raised by the audit. For example; one person had lost weight and they had been referred to the district nurse and nutritional supplements had been requested. However, we found that some areas of care provision had not been checked, such as people's repositioning charts, which are used to ensure people who were at risk of skin breakdown were repositioned regularly. We found that there were some gaps in the recording of people's repositioning, which meant we could not ascertain if people had been supported in line with their plans of care. The registered manager told us that they had not implemented a system to check people's turns were being completed as required, but they would ensure that this was implemented. This meant the provider had acted on feedback and had made improvements to the systems in place, but some further improvements were needed to ensure all areas of the care provided were assessed.

We saw that accurate records were not always available. Staff we spoke with knew people's risks and understood how to support people safely in line with their preferences. However, we found that care plans and risk assessments did not always contain sufficient up to date information of how staff needed to support people. For example; we saw that there were inconsistencies in two people's care plans regarding their pressure care and the frequency that they needed support to move to ensure their pressure areas remained intact. Staff we spoke with were aware of the support these people needed, but there was a risk of inconsistent and unsafe support. People and staff told us that agency workers were used at the service when there were staffing shortages. The registered manager had a system in place to check that records contained up to date information for staff to follow, but this had not always been effective in identifying that records did not contain sufficient or up to date information. This meant that people were at risk of unsafe and inconsistent care when permanent staff were not available to provide support to people because records were not always accurate.

People who used the service told us that they had not been asked their opinion of the care they received. One person said, "Nobody has asked me for my opinion about my care". Another person said, "I've never been asked for my opinion". However, relatives told us that they had been asked about the quality of the care their relatives received. One relative said, "I receive a survey to complete 2-3 times a year and you can offer suggestions". This meant improvements were needed to ensure that people were asked about their views and were enabled to provide feedback about the quality of the service.

We found that records were stored safely. We saw people's confidential records were kept in locked cupboards throughout the day and the keys for these cupboards were carried by senior members of staff or available within the office. This meant that people's confidentiality was protected because their information was secure.

We saw that information about incidents and accidents were audited and analysed by the registered manager who ensured that actions had been taken to lower the risk of further occurrences. For example; one person had fallen and the audit showed that additional equipment had been requested from the physiotherapist and a review of the person's medicines had been requested. This meant there was an effective system in place that identified actions that had been taken to lower the risk of further harm to people.

People and staff we spoke with told us that the registered manager was approachable and they were available at the service on a daily basis. One person said, "I know [registered manager's name] and can always talk to them when they are around". A relative said, "The manager is very approachable, they have an open door policy and any concerns are always addressed". One relative told us they felt listened to by the registered manager and they were able to make suggestions to the way the service was run. They said, "I feel listened to. I recently went to the office and made a suggestion that a family member might be included in the recruitment process". Staff told us they received supervision on a regular basis. One staff member said, "I had supervision last week with the registered manager. I get lots of support and ask any questions I need to". Another staff member said, "I get regular supervision from the registered manager, and I ask questions every day as well. I'm well supported". This meant that people and staff felt able to approach and raise any concerns or suggestions to the registered manager.

A relative we spoke with told us they felt that improvements had been made to the service provided. They said, "I have noticed several changes since the last inspection. I feel it's focussed the management and staff". Staff we spoke with told us that there had been improvements to the service and there were new systems in place to ensure people received their care. One staff member said, "Things have definitely improved. We have attended lots of meetings and staff have more accountability for the support they provide". Staff also told us that the provider visited the service regularly and carried out checks. Staff told us that the provider was also available to them if they needed to ask any questions. This meant that the provider had acted on feedback received to make improvements to the way the service was managed.

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 11 HSCA RA Regulations 2014 Need for consent People who were unable to consent to their care were at risk of receiving care that was not in their best interests because the provider had not acted in line with the Mental Capacity Act 2005.