Wellbeing Care Limited

Wellbeing Care Support Services

Inspection report

43 Cotmer Road, Lowestoft, Suffolk NR33 9PL
Tel: 01502 572591
Website: n/a

Date of inspection visit: 21 July 2015
Date of publication: 04/09/2015

Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 2 April 2015. After that inspection we received concerns in relation to the safety of people living in the service. As a result we undertook a focused inspection on 21 July 2015 to look into those concerns. Our inspection of 2 April 2015 had found breaches of legal requirements after which the provider wrote to us to say what they would do to meet legal requirements in relation these breaches. This inspection also checked that they had followed their plan and to confirm that they now met legal requirements.

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 Wellbeing Care Support Services on our website at www.cqc.org.uk.

The service provides personal care and support to adults with a learning disability who live in flats owned by the provider. On the day of our inspection there were seven people receiving support from the service.

The service did not have a registered manager in place. 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 our focused inspection of 21 July 2015 we found that the provider had followed their action plan and improvement had been made. Legal requirements relating to breaches relating to the key question 'safe' had been met. This was because medicines were now managed safely and there were sufficient adequately trained staff to meet people's care needs. There were also sufficient adequately trained staff to provide the support people required.

However, on this inspection we identified that risk assessments put in place following our 2 April 2015

Summary of findings

inspection did not always do everything practicable to mitigate risks to people. This meant that people were exposed to unnecessary risk when receiving care and support.

You can see what action we told the provider to take at the back of the 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 consistently safe.

Risks to people were not always identified. Where risks were identified actions were not always put in place to minimise the risk.

There were sufficient adequately trained staff to meet people's needs.

Medication was administered safely and managed effectively.

Requires improvement

Wellbeing Care Support Services

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.'

We undertook a focused inspection of Wellbeing Support Services on 21 July 2015. This inspection was completed to check that people were safe after we had received information of concern. We also checked that improvement to meet legal requirements planned by the provider after our 2 April 2015 inspection had been made. We inspected the service against one of the five questions we ask about services: is the service safe.

The inspection team consisted of two inspectors.

Before our inspection we reviewed information we held about the service, this included information the service had provided as to how they would meet legal requirements following our inspection of 2 April 2015. We reviewed statutory notifications received from the provider (a statutory notification is information about important events which the service is required to send to us by law). We also spoke with a relative of a person living in the service and the local authority safeguarding team.

During the inspection we spoke with two people who were receiving support from the service, three support workers and the manager. We looked at five people's support plans, staff duty rotas and records relating to medication.

Requires improvement

Is the service safe?

Our findings

This inspection was triggered because CQC had not received statutory notification of incidents at the service where a person's safety had been put at risk. These incidents had been reported to the local authority who were investigating the incidents. We looked at these incidents and saw that the manager had taken appropriate action following the incident to protect people, including disciplining staff.

At our inspection of 2 April we had identified that risks to people had not been managed appropriately. People did not have free access to come and go from their property as they wished. Risks to people were not managed so that people were protected and their freedom of movement supported. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2010.

At our focused inspection 21 July 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of the regulation. There were appropriate decision making processes in place to ensure that where a person had their freedom restricted this was done lawfully.

One of the people we spoke with who received support from the service told us they felt safe receiving support. The staff we spoke with were able to describe the signs of abuse and were able to describe to us how they would report this. We saw posters with the contact details for the local authority safeguarding team were displayed in the service.

At our inspection of 2 April we had identified that there were insufficient appropriately trained staff to meet people's needs. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2010.

At our focused inspection 21 July 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 11 described above.

People told us that there were sufficient staff to meet their needs. One person gave us an example of how they were able to access the community with the support of staff. Staff we spoke with told us that there were enough staff to provide the care and support required by people.

Staff rota's we checked showed that the service had sufficient staff on duty to meet people's assessed needs. We also checked to see that staff that were supporting people with specific needs had the required training, for example the administration of specialist medication. Training records showed that staff providing support to people with complex needs had received the required training

At our inspection of 2 April we had identified that medicines were not administered safely. This was because it was not always administered as prescribed and there were numerical discrepancies in recording. This was a breach of Regulation 12(g) of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2010.