

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 effective?

Good



Is the service caring?

Good



Is the service responsive?

Good



Is the service well-led?

Requires improvement



Overall summary

This inspection took place on 24 November and 6 December 2015 and was unannounced. At our last inspection on 8 and 20 April 2015 we found the provider was breaching regulations relating to safe care and treatment, safeguarding, staff training and supervision, and good governance. After that inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. As part of this comprehensive inspection we checked whether the provider was now meeting these legal requirements.

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 13 people living in the home.

There was no registered manager in post. The registered manager had left in March 2015 and a new manager was recruited shortly after. However, they had also left the service just over a week before our inspection. An acting manager was in post. A registered manager is a person who has registered with the Care Quality Commission to

Summary of findings

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.

We found that the provider has not made all the necessary improvements to address the deficits we identified at our last inspection.

They continued to manage some risks to people poorly. These risks related to moving and handling, the prevention of pressure ulcers and bed rails. We found that risk assessments were not always carried out to assess risks to people and these were not always kept up to date with current information. Suitable risks management plans to guide staff were also not available.

People were still not safeguarded from abuse. Although staff recorded bruises and other wounds on body maps appropriately these were not investigated by management to check how they occurred so they could take appropriate action to prevent these from happening again.

There was insufficient numbers of staff deployed on shift to meet people's needs. The provider's recruitment campaign to fill vacancies continued.

The auditing systems in place remained ineffective in identifying the breaches of regulations we found during this inspection. In addition, records in relation to the management of the service were not always well maintained.

Medicines management was safe and our checks indicated people received their medicines as prescribed. The medicines policy had been updated to include how 'homely remedies', medicines purchased over the counter, should be administered safely. Staff carried out daily audits of medicines to check people had received their medicines appropriately.

Recruitment was safe and the provider had introduced checks of people's mental and physical health to carry out their roles as required by law. Other checks on staff were carried out such as checks of criminal records, references from previous employment and employment histories, proof of identification and right to work in the

UK. The provider had audited staff recruitment folders and identified some gaps and they were gathering the required information from head office or from staff to keep at the service.

The premises were safe because regular checks were carried out both internally and by external contractors. A maintenance team was in place to carry out day to day repairs which were requested and carried out promptly.

Staff received support to carry out their roles through supervision and a suitable training programme.

People received choice of food and drink and received food in sufficient quantities. People also received the right support to eat and drink and their nutritional status was monitored by staff through regular weighing where necessary. Staff supported people to access health services in order to remain healthy.

Staff understood their responsibilities in terms of obtaining consent from people and supporting them under the Mental Capacity Act 2005. The service was also meeting their requirements under the Deprivation of Liberty Safeguards (DoLS). These safeguards are there to help make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

Staff treated people with kindness, dignity and respect in their day to day interactions with them. Information about people's preferences and backgrounds was recorded and people were involved in developing their care plans. Staff supported people to be as independent as they wanted to be.

A suitable complaints system was in place and relatives told us they were confident in how the provider would respond if they raised concerns with them.

People had individual activity programmes in place based on their interest and a range of activities were offered to people both inside and outside the home.

At this inspection we identified three continued breaches of regulations. These were in relation to safe care and treatment, safeguarding people and good governance. We are taking action against the provider in relation to these breaches and will report on this when our actions

Summary of findings

are completed. We also identified a new breach of regulation in relation to staffing. You can see the action we told the provider to take at the back of the full version of this 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. The provider did not ensure comprehensive and up to date risk assessments were in place for people, with appropriate management plans for staff to follow in reducing identified risks.

People were not always protected against the risks of abuse. When staff observed bruises and other wounds on people these were recorded on body maps but were not always investigated by management to check for abuse.

There were not always enough staff deployed on shift to meet people's needs.

Medicines management was safe as were the premises and equipment. Staff were recruited through safe processes.

Requires improvement



Is the service effective?

The service was effective. Staff received appropriate supervision and training to carry out their roles. People received choice and had the right support to eat and drink. Staff supported people to maintain their day to day health. The provider was meeting their responsibilities in relation to the Mental Capacity Act 2005 and staff understood the need to obtain consent from people.

Good



Is the service caring?

The service was caring. Staff treated people with kindness, dignity and respect in their daily interactions with them. People were encouraged to be as independent as possible. Staff understood the people they worked with well, including their likes, dislikes and backgrounds.

Good



Is the service responsive?

The service was responsive. People were involved in their care planning and care plans reflected their preferences. People had individual activity programmes in place based on their interests. A suitable complaints procedure was in place and relatives had confidence in how the provider would investigate any complaints they made.

Good



Is the service well-led?

The service was not always well-led. Audits had not identified our concerns around risk assessments and safeguarding adults at risk and records were not always held securely or available during our inspection. There was no registered manager in post although there had been a recent change in management and recruitment of a permanent manager had been initiated recently.

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 24 November and 6 December 2015 and was unannounced. It was undertaken by a single inspector.

Before our inspection we reviewed information we held about the service and the provider. 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 four people who used the service. We also 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 also spoke with the chief executive officer, the head of operations, the acting manager, the administrator, three members of care staff and two agency workers. We looked at five people's care records, medicines records, three staff recruitment files and records relating to the management of the service including quality audits. We also spoke with a visiting aromatherapist and a consultant from an organisation commissioned to help develop the service.

After the inspection we spoke with the relatives of three people who used the service via telephone.

Is the service safe?

Our findings

At the last inspection we found the provider did not ensure that risks were appropriately managed to ensure the safety of people. The provider had not ensured the risks to people of developing pressure ulcers had been fully assessed and recorded in risk assessments with suitable management plans in place. This meant staff might not have enough information to support people in relation to this risk. In addition, a person at risk of choking had no risk assessments or suitable management plans in place. This meant they could be at risk of harm due to inadequate risk assessment and planning. The provider had not carried out a risk assessment to identify whether staff on shift required first aid training to deal with first aid issues which may occur. Several people were at risk of choking yet there was no system to ensure staff trained in first aid were on shift. In addition medicines management was not always safe as we could not confirm people received their medicines as prescribed. There was no information in the medicines policy to guide staff on how to administer homely remedies safely and the provider had not considered whether some people should receive homely remedies and how long they should administer them before medical advice was sought.

After this inspection the provider wrote to us with their action plan setting out how they would become meet legal requirements. These actions included having their local health provider assess people at risk of developing pressure ulcers and putting risk assessments in place and training for staff in recognising and preventing pressure ulcers. In addition the provider told us they would put a risk assessment for choking in place for the person at risk of choking on objects left within their reach in conjunction with a speech and language therapist and implement choking prevention guidance to support staff. The provider told us they would implement daily checks on medicines stocks and would review the medicines policy. They also said they would train shift leaders in first aid at work.

At this inspection we found that while medicines management was safe and people at risk of choking had been assessed appropriately, the provider had still not taken the required action to ensure risks to people of developing pressure ulcers were well managed. In addition, risks associated with inappropriate moving and handling

were not always assessed and risk management plans were not in place. Risk assessments and risk management plans regarding the safe use of bed rails were also not in place.

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 even though many people spent most of their time sitting in wheelchairs and were also incontinent so could have 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.

In addition, one person at risk of pressure ulcers had an air mattress in place to help reduce this risk. However the setting for the mattress was set to almost double their body weight which meant it was not being used effectively to reduce the risk of pressure ulcers. In addition the bed rails on this person's bed were ineffective in preventing them being injured by from rolling on to the floor as they were the same height as their mattress. There were no risk assessments or risk management plans in place regarding the safe use of bed rails. We asked the provider how they would make the person safe when we observed this risk and the provider placed a crash mat on the floor next to their bed. The provider told us they would liaise with the person's district nurse to explore how to best manage the risk of them falling from their bed urgently.

During the inspection the provider was unable to locate complete risk assessments with risk management plans relating to moving and handling for the four people who required a hoist to transfer. Two days after the inspection the provider forwarded some related documents. While these risk assessments were comprehensive and had been appropriately completed by an Occupational Therapist (OT) for three people they did not contain current information. For two people these documents were around two years old and for another they had not been reviewed in around 16 months. One person did not have any risk assessments in place, only hoisting guidelines for bathing dated December 2014. This meant information in these documents may not be current and staff may not be

Is the service safe?

supporting people in relation to these risks appropriately. The provider told us they would review these documents though consultation with the relevant health professionals as soon as possible.

These issues were a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found the provider did not have appropriate arrangements for the recording and investigation of bruises. Managers may not have had enough information to rule out whether bruises were due to abuse and to ensure the necessary action was taken to protect people. Body maps showing bruises on people were not reviewed by management to investigate whether bruises were due to abuse. Recording on body maps was sometimes poor and we observed bruises on a person's arm which had not been recorded or investigated.

After the inspection the provider sent us their action plan which set out how they would improve. These actions included further safeguarding training for staff to include proper usage of body maps.

During our inspection we found people were still at risk from inadequate safeguarding practices. While the quality of body maps had improved with all the expected information about injuries such as bruises being recorded, these were still not reviewed by management for investigation into the causes. This meant people could still be at risk from abuse because action was not being taken to prevent their reoccurrences. The provider told us they would put processes in place to ensure body maps were appropriately reviewed by management to check for abuse.

These issues were a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough staff deployed in the home. One relative told us their family member was not taken out of the home. They said the provider told them there were not enough staff to do this and a social services reassessment to increase funding was required to fund the staff. We saw staff did not always have time to sit and interact with people throughout the day and they often appeared rushed in their work. For example when a person was calling out in distress, which later staff told us was due to sickness, in the lounge, staff were unable to respond

promptly to provide them with reassurance. When another staff member was preparing food before a mealtime we saw it was difficult for them to supervise those who entered the kitchen and required their support to stay safe at the same time. Staff told us some shifts were very stressful due to the lack of staffing with several people requiring two staff for moving and handling, two people requiring one to one staff support, while other people required supervision when in the kitchen which they had free access to. One staff member told us, "When staff are all with people in the rooms who is here to watch the others? I worry about this!" The provider did not have a system to assess the required staffing levels to meet people's needs according to their dependencies. The provider acknowledged there were not enough staff and was making arrangements to provide more staff on shifts in the home.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found records of accidents and incidents were not always made appropriately and managers did not always review accidents and incidents reports to ensure staff supported people appropriately and measures had been taken to prevent a recurrence. The provider did not analyse accidents and incidents reports to look for patterns which may indicate concerns such as abuse or changes in people's needs.

After the inspection the provider told us in their action plan they had updated accidents and incidents forms to include accountability, clear actions and time frames and that accidents and incidents forms would be discussed at team meetings as a standing agenda item to encourage learning and peer support. At this inspection we found accidents and incident recording and analysis had improved in the ways set out in the action plan.

At the last inspection we found recruitment practices were not always safe because the provider did not always ensure checks were carried out in relation to staff's capability to perform their roles due to any physical or mental health conditions. The other checks of staff suitability to work were satisfactory. At this inspection we found the provider had introduced health checks through an external occupational health service. We found some required documentation evidencing all the necessary recruitment checks had been carried out for staff, was not in place for some staff. The provider assured us these documents were

Is the service safe?

at head office and were being transferred to the service or would be obtained from staff directly. The provider was fully aware of the gaps in documentation at the service and had compiled a spreadsheet reflecting this. They kept us up to date with progress in obtaining the required documents after the inspection.

The provider had worked with a speech and language therapist to review people at risk of choking and guidance was in place for staff to follow in relation to their choking risk.

Our checks of medicines showed people received their medicines as prescribed and our checks of medicines records showed no omissions in staff recording medicines administration. The medicines policy had been updated to include how homely remedies should be managed safely.

The premises and equipment were safe as the required checks and maintenance were in place. A relative told us, "The premises are always clean, they have the right equipment and we're very satisfied." Regular action was taken to reduce the risk of Legionella infections in accordance with the Legionella risk assessment. Legionella is a bacterium which can accumulate rapidly in hot water systems if control mechanisms are not in place. Checks of the water temperatures to avoid scalding were carried out. In addition, checks of the electric wiring, portable electrical appliances, lifting equipment such as hoists, wheelchairs and of the fire system were in place.

Is the service effective?

Our findings

At our last inspection we found staff were not always supported or trained appropriately to carry out their roles which meant people were not always protected against the risks of receiving poor or inappropriate care. After the inspection the provider wrote to us with their action plan setting out how they would improve. They told us they would review supervision processes and training.

At this inspection we noted that the provider had established an effective system to identify when staff required refresher training had been put in place with a spreadsheet showing staff training requirements. A programme of training was in place and staff had received training in a range of topics since our last inspection. The gaps in training we identified previously such as in first aid, infection control and safeguarding training had been met.

We found the action the provider had taken was sufficient and staff were now supported and trained appropriately. Records showed a robust system of supervision had been put in place by the previous manager which the new acting manager planned to continue. Staff confirmed they had regular supervision with their line manager and they felt well supported. The provider set clear goals in terms of staff performance and staff were motivated through team meetings and supervisions to perform well.

At our last inspection we found staff did not ensure people's weight was monitored regularly when required. This meant staff may not identify changes in people's weight which would indicate concerns about their nutritional state. After the inspection the provider wrote to us to tell us they had obtained a weighing scale suitable for wheelchair users and people were being weighed monthly.

At our inspection we found the way staff monitored people's nutritional status through their weight had improved and people were weighed most months

although some months were missed for some people. Staff took note of any changes in people's weights and were aware of the need to liaise with people's GPs if these changes became significant.

People confirmed staff asked for their consent before carrying out their personal care. At our last inspection we found that not all staff had a good understanding of the requirements of the Mental Capacity Act 2005 and not all staff had received training in this. We however found that the provider ensured best interests decisions were made for people in line with legislation when people lacked capacity to decide themselves. In addition staff were meeting their requirements in relation to the Deprivation of Liberty Safeguards (DoLS) and had applied for authorisation to deprive several people of their liberty as part of keeping them safe. At this inspection we found staff had received training in the Mental Capacity Act 2005 and our discussions with them showed they understood their responsibilities in relation to this, including obtaining consent from people before providing care to them.

People made positive comments to us about the food they were provided. At this inspection we found staff supported people to eat and drink appropriately and the service encouraged people to eat healthily. We observed a mealtime and saw staff supported people in accordance with their care plans. People received a choice of food and drink and people told us the quantities of food were sufficient for them. One person told us, "That's enough for my lunch." People received support from speech and language therapists who guided staff on how to reduce their risk of choking where staff were concerned.

Relatives told us people received the right support to maintain their health. People's records showed they had regular contact with various health professionals such as GP, dentist, optician, psychiatrist, neurologist and district nurse. People were also supported to attend physiotherapy groups run by the provider as well as to exercise in various ways including swimming and hydrotherapy in order to help maintain their health.

Is the service caring?

Our findings

At our last inspection we found staff had a caring attitude when dealing directly with people. We noted that the provider did not show enough concern for people's wellbeing in a caring way as they did not respond to some of their needs quickly enough. For example ensuring appropriate arrangements were in place when people were at risk, particularly in relation to monitoring people's nutritional state adequately to make sure they had enough to eat and drink. In addition the provider did not ensure appropriate action was taken when people had bruises to rule out the possibility that people could have been abused so they could be protected.

At this inspection we found that the provider demonstrated a more caring approach although there was still progress to be made in many areas to ensure people received safe and effective care. They were monitoring people's nutritional status through weighing them regularly and they acknowledged that the risk management system within the home needed to improve.

People made positive comments about the service. One person told us, "It's great here!" Another person said, "Staff are good and kind". A relative told us, "Staff are certainly friendly and caring". Our observations were in line with these comments and we saw staff treated people with kindness, dignity and respect. Staff spent time sitting and interacting with people and took the appropriate care when supporting people to eat and drink so they ate at their own pace. Staff referred to people in a respectful way and showed compassion when people became distressed.

Staff also treated people in a dignified way and we observed staff ensured doors were closed when supporting people with personal care. In addition staff supported people to maintain their personal appearance including helping them to protect their clothes during mealtimes and painting people's nails if they wanted them to.

Our discussions with staff showed they understood people's preferences and backgrounds including people who were important to them, especially the many staff who had worked at the service for several years.

Staff encouraged people to build and maintain their independent living skills. We observed staff encourage people to get involved in preparing the lunchtime meal, supporting people to do tasks they knew they enjoyed and were able to do. People's skills and interest in building and maintaining skills were included in detail in people's care plans for staff to refer to when supporting them. Our discussion with staff showed they had a good understanding of this information for individuals. We observed people were supported in line with their care plans. For example one person was encouraged to boil water before making a cup of tea as this was a particular stage in making a hot drink where they required staff support.

Staff knew the best ways to communicate with people to help them understand information. Staff knew to use simple words and repetition for some people to clarify their message. For another person they used Makaton, a basic form of sign language useful for some people with learning disabilities to communicate.

Is the service responsive?

Our findings

People had a choice of activities to engage in that met their personal interests. One person told us, “We do line dancing and I go to [a local farm]. I go to a [learning disability group] meeting and we talk about things we’re going to do.”

People had individual activity programmes in place based on the activities they enjoyed which helped avoid social isolation. These included going to local social and support groups and day centres, weekly line dancing, horse riding, Zumba, hydrotherapy and visiting family and local shopping centres. Many people chose to participate in trips arranged by the external groups they belonged to and a pantomime was arranged for the forthcoming weeks. Activities were also provided in the home. A ‘music man’ visited the service each week and passed various instruments to people who wanted to participate in his songs. We observed a line dancing session taking place during our inspection. In addition we observed an aromatherapist provide massages to people who wanted this and they told us they visited most weeks. People were supported to develop independent living skills. Two people went to a local centre to learn horticulture and carpentry.

Information in people’s care plans, besides information about pressure ulcer management and moving and handling needs, was up to date and regularly reviewed. Relatives told us the provider communicated well with them about their family member’s progress.

Care plans contained detailed information about how people wished to be cared for to guide staff in supporting them. People had been involved in creating their care plans and they focussed on them as individuals. In addition people’s care plans contained information about their hopes and dreams and how staff should support them in achieving these. Staff regularly reviewed these goals with people as part of ‘keywork’ meetings. A keyworker is a member of staff who works closely with a person to help ensure they receive the right care and support.

The provider told us they had received no complaints since the last inspection. People were provided with opportunities to complain during their keywork meetings and house meetings should they wish to. In addition people had access to advocates who could help them to complain if they wished. We saw that an advocate was visiting a person using the service during our inspection. People and their relatives told us they would complain if necessary and were confident the management would respond appropriately. One relative told us, “You get the impression if you complained they’d be very responsive.”

Is the service well-led?

Our findings

The provider quality assurance systems were not very effective to protect people from the risks of unsafe or inappropriate care. At the last inspection we found a breach in relation to the 'good governance' regulation. This was because people were not protected against the risks of poor and inappropriate care as the provider did not have effective systems in place to assess, monitor and improve the service as these had not identified the issues we found at our inspection. In addition they did not always ensure records were well maintained.

After our inspection the provider wrote to us with their action plan to improve in relation to this breach of regulation. They told us they would review all systems and processes including those for recording and reporting incidents and wounds such as bruises. They planned to recruit an administrator to help improve quality assurance systems within the service. In addition they planned to monitor the new systems through audits by the manager and responsible person. The responsible person's audit tool was to be revised based on CQCs five key questions.

At this inspection we found the service had improved in some areas, but overall the action taken to improve had been insufficient. The head of operations and responsible person had carried out various focused audits, such as for recruitment and care plans. These had identified issues which had since been resolved. The manager had carried out monthly audits of medicines management processes. Daily audits of medicines carried out by staff had ensured people received their medicines as prescribed. The administrator had audited staff recruitment folders and staff training and supervision and the provider had put in place a suitable training and supervision programme. However, audits had not identified the issues we found such as those relating to risk assessments and safeguarding.

In addition the provider could not locate many records we requested during our inspection and had to send these to us via e-mail. These included records relating to health and safety checks and some people's risk assessments in relation to manual handling. These are important records that describe the care service users needed and about mitigating risks and might be needed promptly for staff to refer to if they needed to read these to find out about the care the service users needed.

These issues were a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager in post. Since the previous registered manager retired around April 2015 another manager had been recruited who had applied to register with CQC. However, they had left their post just over a week before our inspection. An acting manager was in post at the time of our inspection while the service recruited a permanent manager.

Leadership was visible at all levels. The provider had recently restructured the senior team to include more leadership in the senior roles with an increase in senior positions which were still being recruited to. Each senior staff member had a designated area of responsibility such as medicines, quality assurance or activities and their role included time to spend on administration tasks. The senior staff organised shifts well with thorough handovers which included clear delegation of tasks which was recorded to provide an audit trail. The acting manager knew the service well and had managed the supported living service run by the provider for many years.

The provider had recently commissioned a company to support them strategically to ensure people's rights were protected and their vision that all people should be given a fair chance in life and be guided to flourish themselves was promoted. During our inspection we met the organisations representative who was carrying out their initial visit to the service.

The provider had strong links within the local community offering a range of support services for people with learning disabilities. These included employment support services, support and advice for people with Asperger's syndrome, independent travel training, workplace mediation, a catering kitchen and a community café, a gardening project and transport services. Some people from the service had regular involvement with the gardening project in particular and were encouraged to participate in other relevant services.

People using the service were involved in developing the service. People were offered keywork and 'house meetings' regularly where they could raise issues. In addition people were supported to access advocacy services through which they could raise issues.

Is the service well-led?

Staff were also involved in developing the service through participation in a staff forum where issues affecting the whole organisation were discussed, as well as through regular team meetings. Staff told us they felt able to raise issues in these meetings and that they were listened to.

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
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Regulation 18 HSCA (RA) Regulations 2014 Staffing

There were not always sufficient numbers of staff deployed at the service.

Regulation 18(1)