Wellbeing and Support Limited

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Inspection report

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Date of inspection visit:
15 June 2021
24 June 2021

Date of publication:
23 July 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Wellbeing and Support Limited is a domiciliary care service. The service provides care and support to people living in their own homes. During the period of the inspection the number of people using the service decreased from eight to two.

People's experience of using this service and what we found
People's safety, health and welfare had been put at risk due to poor governance, and their being not enough staff to meet people's needs. This had resulted in people experiencing missed calls or calls at times which did not meet their needs. Family members and others had met the staffing shortfalls by providing personal care to their relatives. Family members spoke of poor communication, often being given short notice of there were not being enough staff to cover their relatives care calls.

Family members were aware of managerial and staffing difficulties and told us they had either secured or were in the process of securing alternative providers to meet the care needs of their relatives. In some instances, family members had been supported by office-based staff to identify alternative providers, and some spoke of support offered by commissioners.

The registered manager had terminated their employment in March 2021 and the service was initially managed by the nominated individual (The nominated individual is responsible for supervising the management of the service on behalf of the provider) who had submitted an application to register as manager with the Care Quality Commission (CQC). However, CQC have been unable to progress the application due to their unavailability. The nominated individual appointed an interim manager who had been in post for seven weeks at the time of the inspection.

The manager informed us their priority and focus had been in managing care calls to ensure people's needs were met, as much as possible. They spoke of ongoing staff resignations, which had impacted on their ability to meet people's needs. The manager confirmed people, or their family members were in the process of identifying alternative providers. The number of people using the service, and the number of staff employed decreased during the period of the inspection.

The provider had failed to ensure policies and procedures were followed, which included the quality and quality monitoring policy, complaints and medication policy. This meant opportunities to improve the service and people's outcomes had been missed.

The providers approach to ongoing support and monitoring of staff was not consistent, which meant opportunities to drive improvement had been missed.

Potential risks to people's safety had been assessed with regards to their individual needs and the environment in which care was to be provided. Care plans had been developed which provided information

as to how risks were to be minimised.

People received support with their medicines. However, improvements were needed to medication records.

Family members and staff told us they would not recommend the service. Family members told us staff were king and caring where they had been supported by a consistent group of staff, positive relationships had developed.

Staff recruitment processes ensured staff were suitable to work with people. Staff had undergone training at the commencement of their employment.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on 11/11/2019 and this is the first inspection.

The inspection was prompted in part due to concerns received that there were not enough staff employed to ensure people's packages of care were provided, which had resulted in late or missed calls. We also received information that staff were not always wearing personal protective equipment (PPE). A decision was made for us to inspect and examine those risks.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to not enough staff being employed to meet people's needs and poor governance and leadership.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our safe findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Wellbeing and Support Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own home

The service did not have a manager registered with the Care Quality Commission (CQC). Registration with the CQC means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or manager would be in the office to support the inspection.

The inspection activity started on 14 June 2021 and ended on 25 June 2021. We visited the office on 15 and 24 June 2021.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require provides to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the service was registered. We sought feedback from the local authority who commissioned with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with seven family members about their experience of the care provided. We spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. The manager, care co-ordinator and senior team leader. We contacted 12 members of staff by e-mail to seek their views, and four members of staff responded.

We reviewed a range of records. This included two people's care records and medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including monitoring of quality and risk, policies and procedures and minutes of meetings.

After the inspection
We continued to seek clarification from the provider as to their plans going forward for the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated as Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- People's safety, health and well-being were placed at risk. People had experienced missed calls.
- Family members spoke about the last 2 – 3months of them being regularly contacted and informed that as a result of staff shortages, they were unable to send staff to care for their relatives. This meant family members had made alternative arrangements, which in most instances meant family members provided the care themselves. A person told us, "I've had to provide the care for [person's name] the last five weekends."
- The manager told us people's calls were being cancelled as there were not enough staff employed to meet people's needs. They spoke of their approach as 'firefighting'.
- All family members we spoke with told us they had found or were in the process of finding an alternative provider to meet their relative's needs.

The provider had failed to ensure there were sufficient numbers of staff employed to ensure people's care needs were met. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- Staff were recruited safely. Staff files contained a full employment history, a record of the interview and evidence of satisfactory references and a Disclosure and Barring Service check.
- Potential staff had been screened for their suitability to work with people.

Using medicines safely

- Systems to record the administration of medication needed to be improved. Records relating to medication administration were not robust. For example, a medication administration record (MAR) showed staff did not always sign to confirm medication had been administered. The manager said they would review medication records and take any necessary action to bring about improvement.
- Staff had undertaken training in the safe management of medicine, however some staff's competency in medicine management was not assessed.
- The provider had failed to adopt their administration of medicine policy and procedure.
- People's care plans recorded the medication they were prescribed, and the role of staff in prompting or administering medication when required.
- Family members told us staff managed their relative's medication well, and that staff recorded medication had been prompted or administered dependent upon the level of support required.

Learning lessons when things go wrong

● Systems and processes to learn from feedback about the provision of care were not robust. For example, quality monitoring processes were not robust, which meant areas for improvement were not noted.
● Staff were aware of their responsibilities to record and report accidents or incidents to office-based staff.

Preventing and controlling infection
● We received concerns prior to the inspection that staff were not consistently wearing personal protective equipment (PPE), which includes, gloves, aprons and masks. Family members told us this had now improved. The manager told us staff collected PPE from the office and documented this.
● Staff were routinely tested for COVID-19 at local testing centres, and their results were shared and recorded by the provider.
● Staff informed us they had received guidance on the correct use of PPE and information about COVID-19.

Systems and processes to safeguard people from the risk of abuse
● Staff had been trained in safeguarding procedures and knew what action to take to protect people from harm and abuse.

Assessing risk, safety monitoring and management
● Potential risks to people's safety and their home environment had been assessed. Care plans provided staff with guidance as to how to support people, the number of staff required and equipment to be used to maximise people's safety.
● People had information in their care folder. This had essential information about people's care needs including their medicines, which could be shared with health care professionals in the event of an emergency or hospital admission.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated as Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Records used to monitor staff competency through observed practice had not been kept up to date. The majority of records were for staff who had terminated their employment, and some staff who were working for the provider were not included in the data held.
- Staff's induction to their role was inconsistent. One staff member stated. 'I didn't really get any induction, I had on evening shadowing (working alongside another member of staff) and that was it. I had no assessment, and I completed some online training before I started.'
- Staff confirmed they had received training in key topics.
- Staff had been supervised, which had included spot checks. However, information provided by staff showed the frequency and quality of these differed.

Supporting people to eat and drink enough to maintain a balanced diet

- The provider had failed to ensure people's nutritional needs were consistently met. Staff shortages meant the provider was unable to meet its contractual commitments in meeting people's needs. This had meant a family member had in some instances had to provide the support and care, which included the provision of meals and drinks.
- People's needs related to nutritional needs were documented within their care plan and records, which included information as to their meals and drink preferences.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs had initially been assessed when they started using the service and had been reviewed to ensure information held within the care documents was up to date and reflective of people's needs.
- Equipment to support people to maintain their independence was detailed within their assessment.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People's care records provided information as to people's physical health, including any health conditions which impacted on their day to day lives.
- Staff confirmed their understanding as to their role and responsibility in liaising with health and social care professionals where required, including emergency situations. Staff were aware of their responsibility in reporting concerns to family members, and the management team.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

- People's care records provided information as to their involvement, and that of family members in decisions relating to their care.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated as Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People's needs had not consistently been met in a timely way. A family member told us the timing of calls had recently changed due to staff shortages, which meant staff arrived at times different to those agreed. Some family members told us they had not experienced changes in call times.
- Family members spoke positively of care staff, telling us staff were kind and considerate when providing care. They spoke of positive relationships being developed when their relative had had the same care staff provide care.
- A family member told us how staff went that 'extra mile.' They told us, "My [spouse's] shower cap was mislaid recently, and today the carer having bought a new one, brought it with them."

Supporting people to express their views and be involved in making decisions about their care

- Family members had mixed views as to whether staff had a good understanding of their relative's needs. Some stated staff who were unfamiliar with their relative's needs, didn't always read the care plan, and even when they did, still relied upon them to guide them in how to provide the care.
- People's care plans included information to support their independence. For example, by detailing what areas of personal care people managed independently and areas where assistance was required.
- A staff member stated. 'With all those I work with prompting independence is key. An example would be if a person is able to drink from a cup themselves this should encouraged rather than a carer holding the cup for the person.'
- People's care plans had been reviewed until recently, and family members confirmed they had been involved in the review process.

Respecting and promoting people's privacy, dignity and independence

- A staff member stated. 'Dignity is so important, putting yourself in the persons' shoes is really helpful, ensuring they always feel comfortable is absolutely necessary. I always make sure when completing any moving and handling, the people I work with are being covered up and respected.'

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated as Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- The provider had an electronic system which required staff to log in, when they arrived and left a person's home. However, due to staff shortages some people's call times were not always consistent with those agreed or detailed in their care plan.
- People's needs, and expectations of care had been clearly documented within their care plan, which included their preferences. For example, the order in which they liked their care to be provided and included areas they were independent in.
- People's records provided information to support staff in developing relationships. For example, information as to people's hobbies, interests, work and family lives.

Improving care quality in response to complaints or concerns

- Systems and process for the recording of complaints needed improving. A recent concern dated 20.05.21, detailed the name of the complaint and was recorded as '[person's name] concerns about carer, was on the phone for 25 minutes. 'The action to be taken was recorded as 'will speak to carer'. No information as to the nature of the concerns, or evidence to support the concerns had been responded to were documented. The manager was unable to provide any further information when asked.
- People told us they were confident to raise concerns. However, people's views were mixed as to whether concerns recently made had been acted upon or had brought about positive change. A family member told us they had repeatedly asked for a rota so that they knew what time staff would be arriving, however this had not been provided.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were documented. For example, care plans referred to staff supporting people with the use of hearing aids and glasses.

End of life care and support

- At the time of our inspection no one using the service required end of life support.
- The service had an end of life care policy and staff had received basic training and information in this area.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated as Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Working in partnership with others

- The service did not have a registered manager. The Nominated Individual applied to register with the Care Quality Commission (CQC) as manager in April 2021. However, CQC has been unable to progress with the application, as the nominated individual has not been available. This meant the service had been left without a registered person being in day to day charge of the service.
- The inspection was facilitated by the 'interim' manager who had been in post for seven weeks at time of our site visits. The manager informed us they had limited information about the service, its systems and processes or knowledge of the people using the service. They referred to their current role as 'firefighting', with their primary focus on ensuring staff were available to deliver people's care and support, until their packages of care could be transferred to alternative providers.
- Poor oversight and governance had resulted in an inability by the provider to respond in a timely way to ensure people's safety and wellbeing was ensured through the provision of care. This had resulted in people experiencing missed calls.
- The provider had failed to ensure policies and procedures were adopted, which included the medicines policy, the complaints policy, and the quality and quality assurance policy.
- Quality assurance and auditing processes had ceased to be implemented in key areas. For example, medicine management, daily records or oversight and management of concerns and complaints. This restricted the provider's ability to monitor and improve the quality of care and the service provided.
- Systems to monitor staff training and competency to ensure staff had up to date skills and knowledge for their roles were flawed. A matrix recording the names of staff employed, their training and monitoring were out of date and did not reflect the staff currently employed.

The provider failed to ensure effective systems were in place to assess, monitor and improve the quality of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and family members we spoke with told us they had secured or were in the process of seeking an alternative provider to provider their package of care, due to the unreliability of the service. Many people had experienced 'missed calls'. Family members told us they had had no alternative but to care for their relative themselves.

● Records showed people's views had been sought. However, these were not always dated and where people had commented upon areas for improvement there was no information to support what action if any, had been undertaken.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Family members spoke positively of the service until the recent resignation of the registered manager in March 2021. They told us the service had until then been well-led and reliable.

● Family members in some instances spoke of the support provided by office-based staff in helping to identify alternative providers, to meet their care needs of their relative.

● Staff referred to the recent decline in leadership and its impact. A staff member stated. 'Wellbeing and Support Ltd has drastically gone downhill in the past 3 – 4 months. I have been planning to hand in my resignation for some time. However, I have stayed due to the fact that the people have such limited carers available, I have felt so guilty that they would be without care.'

● Staff reflected on poor communication. A staff member spoke of having arrived at a person's home on three occasions to provide care and the person not being at home. The staff member went onto say the person had been admitted to hospital, but they had not been told.

● We asked staff if they would recommend the service . A member of staff stated. 'No, I would not feel comfortable with a family member or friend being looked after by Wellbeing and Support Ltd. On one hand we have a group of brilliant carers who work very hard and have absolute respect and love towards their job and people. However, on the other hand the management is too poor to put any trust in the company for someone close to me to be under their care.'

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
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure effective governance and leadership of the service and the implementation of policies and procedures to monitor the quality of the service.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were enough staff employed to meet people's needs.