Whincup Care Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 9 and 10 January 2018 and was unannounced. This was the services first inspection following registration in February 2017. The service provides support for people with learning disabilities or autistic spectrum disorder. It is registered to accommodate up to six people. At the time of our inspection there were three people using the service. The service requires a registered manager to manage the service. There was no registered manager in post at the time of our inspection. The previous registered manager left their post in March 2017. However, the service did not start operating until August 2017 and manager arrangements were in place. The person managing the service at the time of our visit had recently put forward an application to become the registered manager of 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.

Whincup Care is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service accommodates six people in one adapted building.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

Medicines were not always managed in line with best practice. We saw some medicines were crushed without authorisation from the GP or pharmacist. In addition there was no protocol in place for the administration of 'as required' medicines. However, this was address with immediate effect by the person managing the service.

People were protected against abuse and neglect. Staff we spoke with were knowledgeable of the procedure to follow if they had any concerns or suspected abuse had occurred. Safeguarding information was displayed throughout the premises.

We observed staff engaged well with the people using the service and spent quality time with people without rushing them. Staff received training and support to enable them to carry out their role. We were told that specific training was being sourced to ensure staff could communicate effectively with the people they supported. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Risk assessments were in place to ensure people's safety. Where risks were identified a support plan was formulated to provide people with safe care and support.

The service did not follow the requirements of the Mental Capacity Act 2005. We did not see recording of consent and best interest decisions. People who lacked capacity did not have relevant assessments and documentation in place to ensure they, or people acting on their behalf, had consented to living at Whincup Care.

Accidents and incidents were recorded. However, reportable safety incidents had not been submitted and reported in line with legislation.

People were able to choose food of their choice. Where specific nutrition was required the service accommodated this.

Responsive care was provided to people, wishes preferences likes and dislikes were considered when planning care and support. People were able to access the community in a variety of ways.

People and their families were given a complaints procedure when they first joined the service. This was in an accessible format for people using the service.

The service did not have effective systems in place to monitor the quality of care by way of auditing and monitoring visits.

Staff told us it had been, 'a roller coaster' since the service began operating. However, most of the staff we spoke with said they were confident the new manager would be able to bring about a service that was consistent in its approach and to move things forward.

The new manager of the service encouraged an open culture to enable staff to feel any concerns they had would be listened to. The service was new and staff were working together to develop a good team to support people. Staff said they were looking forward to working together to ensure the service provided good care.

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

The service was not always safe.

People were at risk because of ineffective management of medicines.

Safety incidents were not reported or investigated to keep people safe.

People told us they were happy living at the service. Relatives said their family member was well looked after and safe.

Is the service effective?

Requires Improvement

The service was not always effective.

The service did not follow the requirements of the Mental Capacity Act 2005. We did not see recording of consent and best interest decisions.

People had access to appropriate healthcare professionals and advice was sought when required.

Staff told us they felt supported and received regular supervisions and training to enable them to carry out their role.

Is the service caring?

Good

The service was caring.

People received kind and compassionate care. People's dignity was respected.

People and their relatives were involved in the care planning process.

Is the service responsive?

Good

The service was responsive.

People's care needs were documented.

People were given a complaint procedure to follow when they first joined the service.

Meetings were in progress to ensure people and their families would be able to share their views and suggestions about the way the service was run.

Is the service well-led?

Requires Improvement

The service was not well led.

The service did not have a registered manager at the time of our visit.

We had not received information about notifications when they occurred.

Effective auditing systems were not carried out to monitor the quality of the service

Whincup Care Limited

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 9 and 10 January 2018 and was unannounced. The inspection was carried out by one inspector.

We gathered information about the service prior to our inspection. This included notifications we had received. A notification is information about important events which the service is required to send us by law. A Provider Information Return (PIR) was not requested before the inspection. A PIR is a form that asks the provider to give some key information about the service what the service does well and improvements they plan to make.

Due to communication difficulties we were only able to speak with one person who used the service. We also spoke with one family member, an advocate who regularly visits the service, the person managing the service, the owner of the service and three members of staff.

We looked at the medicine records for each person using the service. Three care plans, including individual risk assessments. We also looked at four staff files, and records associated with the management of the service.

Requires Improvement

Is the service safe?

Our findings

Staff received training in safeguarding of vulnerable adults. Staff told us they knew what to do if they had any concerns with people's safety. One family member told us, "If I was worried I would take them home." The family member had two members of their family living at the service. The person we spoke with told us they were happy living at Whincup Care Limited. The advocate we spoke with told us, "There are teething problems, but the service has huge potential."

Medicines were not managed in line with current guidance and best practice. We were aware that one person had been having their tablets crushed since they were admitted to the service without the authorisation from the pharmacist and GP. Giving crushed tablets without direction from the prescriber and without making the appropriate checks means the tablet becomes 'off licence' which means the manufacturer does not accept responsibility for any harm caused by taking the medicine in this way. We discussed this with the person managing the service and they contacted the prescriber who informed them not to administer the medicine in this way.

We also saw several missing signatures for medicines on the medicine records charts we looked at. In addition correct codes were not used when people were on social leave. This means the members of staff administering medicines could not always be sure if the person had received their medicines. We were also aware the service did not have a 'when necessary' (PRN) medicine protocol in place at the time of our inspection. PRN medicine is administered when a person presents with a defined intermittent or short term condition, for example, not given as a regular daily dose or at a specific time. We discussed this with the person managing the service and they said they would address this with immediate effect.

We recommend a robust auditing tool endorsed by national guidance such as National Institute for Health and Care Excellence (NICE) is used to monitor the safe use of medicines in the service.

Risk assessments were in place and we saw that people were involved in decisions about risks. We saw one person was on a low fat healthy diet as their weight had increased. The person's support plan made reference to 'sometimes (person) makes unhealthy choices in relation to the food they eat.' This demonstrated the service managed risk and did not prevent people from having choice and control. In addition where stricter management of risk was required, the service ensured this was documented and adhered to by staff. For example, people with epilepsy. We saw this was clearly recorded in relation to the management of such risk. In particular at higher risk times such as bathing and going swimming. The support plan had clear guidelines for staff to follow to ensure risks were minimised whilst still allowing the person freedom of choice.

A Personal Emergency Evacuation Plan was in place for each person. Each plan was specific for each person relating to how to support them in the event of an emergency such as a fire. For example, we saw that one person would become anxious in the event of loud noises such as a fire alarm going off. Staff would support the person by using as much sign language as possible.

The service ensured there were sufficient staff to meet people's needs. Recruitment was on-going and agency staff used when required. The service used only one agency for consistency and to ensure the people using the service were familiar with the staff that supported them.

The service followed safe recruitment practices. We looked at recruitment files for four staff and found the service had completed the necessary checks for new staff. Files included proof of identity, job history and references. We saw the provider completed Disclosure and Barring Service checks (DBS) to make sure people were suitable to work with vulnerable people.

The service was kept clean and hygienic to ensure people using the service were protected from infections. Staff carried out the cleaning duties of the premises and understood their roles in relation to infection control practices. Staff completed training in infection control. We saw the kitchen and equipment were cleaned to high standards and specific colour coded boards were used in the preparation of food. Foods in fridges were correctly labelled with expiry dates clearly marked.

Requires Improvement

Is the service effective?

Our findings

People's needs were assessed prior to living at Whincup Care. We saw people's social, physical and mental health needs were taken into account when carrying out pre assessments. We were aware of one person being assessed by the service and were due to visit the service to meet the other people living there before formally moving in. The provider had taken steps to meet the person's cultural needs by ensuring a member of staff was available that was able to speak their first language.

The service ensured staff had the skills to meet people's needs. Topics staff had completed were safeguarding, nutrition, moving and handling and fire awareness. Specific training had been sourced to ensure all staff could communicate effectively with the people they supported. For example the service was in the process of ensuring staff completed Makaton training. The training certificates we saw confirmed training had been completed by staff working at the service. Agency staff told us their recruitment agency ensured their training was completed and up to date. The service was sent confirmation of this before agency staff was requested.

Supervisions were carried out to ensure staff felt supported in their role. An agency member of staff told us they were given an introduction to the people living at the service and were able to read care plans to ensure they were aware of any specific needs. They told us, "I feel very supported and feel I could approach senior staff if I needed to." A permanent member of staff said, "It's been a struggle, but the new manager has been a massive support, the service is great."

The service supported people to maintain a balanced diet. People were able to choose the food they wanted with support from staff. The service encouraged people to cook meals and snacks for themselves with support from staff when necessary. Specific dietary requirements were addressed. For example, one person required particular food due to their religion; another person was having a healthy low fat diet in order to lose weight. We saw people were able to choose when they had their meals. One person did not rise until late morning on both days of our inspection. The person's meal times were adjusted to accommodate this.

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 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 interest and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when it 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.

The service did not follow the requirements of the Mental Capacity Act 2005. We did not see recording of consent and best interest decisions. People who lacked capacity did not have relevant assessments and

documentation in place to ensure they, or people acting on their behalf, had consented to them living at Whincup Care. Additionally we saw that one person had restrictions placed on them regarding them leaving the service on their own. We did not see the service had applied for a standard authorisation relating to depriving the person of their liberty. We discussed this with the person managing the service and they told us this would be addressed. We have requested further information following our inspection.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Good

Is the service caring?

Our findings

One family member told us, "The service has great potential." A person we were able to speak with told us they were happy living at Whincup Care. An advocate commented, "From my perspective people are well cared for."

We observed staff treated people with kindness in their daily routine. Staff took time to listen to people and spoke with them in a way they could understand. We were aware one person had an appointment but was taking their time to get ready. Staff knew the person well and used specific techniques that encouraged the person to get ready for their appointment. For example, helping them choose their clothes and periodically pointing out what the time was.

Rotas were organised to ensure staff were able to accompany people to their appointments when necessary. We noted that a member of staff was accompanying a person on their appointment. Staff made an effort to get to know people. We discussed the daily routines of people with an agency member of staff and they were able to tell us people's routines. They told us they had been able to spend time reading each person's care plan during their induction.

The service provided information in a way people could understand. The service gave an easy read service user guide to people when they first joined the service. Information was provided by way of pictorial formats to ensure they understood what they could expect from the service.

Staff made sure people's privacy and dignity was respected. One member of staff we spoke with told us one person was not comfortable with male staff supporting them. This was recorded in the person's care plan to ensure the person's wishes were addressed. In addition the person wore a red bracelet and the care plan made reference to, 'If I take off my red bracelet it means I am stressed or worried and I need help'. This demonstrated the service used a variety of ways of ensuring people were able to communicate in their preferred way.

The service promoted young adults choice about the amount of parental involvement in their care and support. One parent told us, "I come in every week but intend to take a step back." The service had no restrictions on when family and friends could visit.

People could be as independent as they wanted to be in a supportive environment where people could develop the skills necessary for them to achieve their full potential. Information was given to people and their families about advocacy services and community organisations to support this.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Care plans were detailed and captured people's daily routines. Personal history, individual preferences and interests were documented and understood by staff to ensure people had as much choice and control as possible. During our inspection we saw the person managing the service was in the process of updating people's financial arrangements. This allowed people to have access to their money at a time that suited them, whilst keeping robust records ensuring consistency in the management of people's finances.

People's needs were reviewed as needs changed. We saw one person was reviewed by the dietitian to support them to follow a healthy eating diet in order to lose weight. We noted that the service encouraged the person to be more active as part of their weight loss programme. People were supported to receive care that reflected their preferences. Staff told us that one person prefers female staff to assist them during personal care. This was recorded in the person's care plan.

The service encouraged people to be members of society within the local community. People were supported to maintain relationships with people that matter to them to avoid social isolation. We were aware that all the people living at Whincup Care attended either college or had other sources of work related activities. We saw that one person attended work at a food bank and another person had a farm job. In addition one person attended college three times each week.

The service encouraged people to maintain their particular identity in relation to their culture and religion. We noted that one person was in the transition of being admitted from their home to the service. They had the opportunity to visit the service on several occasions to get to know the other people living at Whincup Care. We saw that the person required specific food in relation to their religion and required regular visits to their place of worship. The service acknowledged the person's specific requirements before they came to live at the service.

People and their families were given a complaints procedure prior to living at the service. People were encouraged to give their views. Where a person was unable to voice their opinion an advocate would be contacted to ensure the person was able to communicate their opinions or worries. At the time of our inspection there had been no complaints about the service.

At the time of our visit the service was in the process of ensuring people and their families were able to have their preferences and choices in relation to end of life care recorded and kept under review.

The service had not held any family meetings at the time of our inspection. However, we were aware the person managing the service was in the process of implementing regular reviews and meetings with families. In addition regular staff meetings were due to be implemented to allow staff to air their views and opinions about how the service was run. We noted the person managing the service had only been in post since December 2017 and they told us, "There are quite a few things on my to do list."

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the service did not have a registered manager. The previous registered manager left their post in March 2017. However, the service did not start operating until August 2017. The person currently managing the service had recently put forward an application to become the registered manager of the service. Staff told us the manager was approachable and was always available to speak with if they had any concerns. Comments we received from staff were, "I feel supported and am very well looked after." "(Name) has been a massive support." The family member we spoke with said, "We must look forward, the service has great potential."

Staff understood the vision of the service which included involvement, independence and equality. We saw the services aims and objectives which promoted this. The manager and staff acknowledged the key challenges of the service. Which were the on-going recruitment of staff with correct skills and attitudes, and to carry out robust auditing and quality monitoring to allow the service to grow and develop.

At the time of our visit audits were not in place to monitor the quality of the service. The manager had completed daily monitoring of medicines. However, these did not highlight the issues we identified.

We recommend robust auditing methods are used to ensure the service is able to measure the quality of care.

Meetings took place with staff. However, we could not see minutes had been taken to show discussions that had taken place. The manager acknowledged this was an area to develop as part of the services on-going development plan. Following the inspection the provider sent us copies of minutes of staff meetings that were not available during our inspection visit.

The service worked in partnership with other healthcare professionals such as dietitians and GPs. Referrals had been made when required.

The service had not notified the Care Quality Commission (CQC) of significant events which had occurred in line with their legal obligations. We found safety incidents were not reported internally and externally. We noted an incident when one person had been able to have in their possession all their medicines from their cabinet which should have been locked. The incident had not been investigated appropriately and reported in line with legislation. Records relating to this incident stated the person gave all their medicines to a member of staff. However, no investigations or actions taken to prevent reoccurrence were evident.

This was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009. The service had not ensured the Commission had been notified of important events when required to do so.

The provider has a legal duty to inform the CQC about certain changes or events that occur at the service. There are required timescales for making these notifications. We had not received information about notifications when they occurred. We noted one incident which had significant safety implications for one

person had not been reported or investigated by the service.

Providers are required to comply with the duty of candour statutory requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use the service and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity. We discussed this requirement with the person managing the service. They told us they were aware of the requirement. However, we were aware the duty of candour requirement had not been used in relation to the incident we identified.

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 18 Registration Regulations 2009 Notifications of other incidents The service had not ensured the Commission had been notified of important events when required to do so.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service did not follow the requirements of the Mental Capacity Act 2005. We did not see recording of consent and best interest decisions.