Akari Care Limited

Wellburn House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out this inspection on the 10 March 2016 and 7 April 2016. The inspection was unannounced which meant the staff and registered provider did not know we would be visiting

Wellburn House is a 90 bedded purpose built two storey care home. It has two units; the ground floor unit for people with personal care needs and the first floor unit for people living with dementia. All bedrooms have ensuite facilities and there is the availability of a large courtyard garden.

On the first day of our inspection the service had a manager who was planning on registering with the Care Quality Commission. We were informed before the second day of inspection that this manager no longer worked at Wellburn House. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last full inspection of the home in July 2015 we found six breaches. These were in relation to safe care and treatment. We found medicines were not managed safely and people were at risk on receiving incorrect nutritional intake. There was also a breach in relation to Premises and equipment. The cleanliness and condition of the service was not maintained. Staff did not receive support through supervision. Staff were not seeking consent before any care or treatment was provided. The service was not safeguarding service users from abuse and improper treatment. People were being deprived of their liberty without lawful authority. Audits were not taking place and people's views were not sought. We also made a recommendation that the registered provider looks at the dining experience for people who used the service, care plans to become more person centred and to ensure people are involved in the care plan development and review where they are able.

Following concerns being raised we also completed a focused inspection in November 2015. This inspection concentrated on looking at whether the service was 'safe'. We found that action was needed to ensure fire procedures were effective; people received appropriate care and treatment; recruitment procedures were safe; and staffing levels met the needs of the people who used the service.

During this inspection we found measures to improve the service had not taken place.

Medicines were not always managed safely for people and records had not been completed correctly. People did not receive their medicines at the times they needed them and in a safe way. Medicines were not administered and recorded properly.

Although the manager had knowledge of the Mental Capacity Act [MCA] 2005 and Deprivation of Liberty Safeguards [DoLS], records made it difficult to understand who was subject to a DoLS authorisation. We checked this on the second day of inspection but due to records the area manager could not establish who

had a DoLS authorisation or where a request had been put in.

Risks to people's health or well-being had not always been assessed and plans were not always put in place to protect people. One person who had grade four pressure sores was placed on two hourly turns and 30 minute observations. There was no record of two hourly turns or 30 minute observations taking place.

Accidents and incidents were not monitored each month to see if any trends or patterns were identified.

We found people were cared for by insufficient numbers of staff. People were left sitting alone in wheelchairs due to needing two members of staff for support and two members of staff not being available. Recruitment and selection procedures were in place but appropriate checks had not been undertaken before staff began work. Staff did not receive support through supervision or did not receive relevant training.

Staff we spoke with understood the principles and processes of safeguarding, as well as how to raise a safeguarding alert with the local authority. Staff said they would be confident to whistle blow (raise concerns about the home, staff practices or registered provider) if the need ever arose.
On the first day of inspection staff did not feel they were supported by the manager. One staff member had highlighted risks and concerns to the manager. However the manager did nothing with the concerns raised.

The area manager carried out monthly quality monitoring reports. These reports did not highlight any issues or concerns we found during inspection.

People were provided with a meal and choice of vegetables downstairs and enjoyed the food on offer. However the dining experience on the unit for people living with a dementia needed improving. People were asked in the morning what they would like for lunch the following day.

People's care records needed to be more person centred. Person centred planning [PCP] provides a way of helping a person plan all aspects of their life and support, focusing on what's important to the person.

Staff were observed to know people well and to be caring. However due to lack of staff people's privacy and dignity was not always respected.

Staff meetings did not take place regularly. No meetings for people who used the service or their relatives took place. Feedback of people's views was not sought.

People were supported to access healthcare professionals and services.

Activities were taking place. People were happy with what activities were on offer.

We saw that the service was clean and tidy and there was plenty of personal protection equipment [PPE] available.

We saw certificates for safety checks and maintenance which had taken place within the last twelve months such as fire equipment, electrical safety and water temperature checks.

The registered provider had not been sending CQC notifications about incidents. Statutory notifications include information about important events which the registered provider is required to send us by law.

We identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014. You can see what action we told the registered provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. Improvements were needed in many areas where the provider was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe
We found that improvements needed to be made in regard to management of medicines.

Staff were knowledgeable in recognising signs of potential abuse and knew how to report any concerns. However concerns were not acted upon.

Assessments were not always undertaken to identify risks to people using the service and others.

There were insufficient numbers of staff to care for people's needs.

Is the service effective?

Inadequate

The service was not always effective.
Staff did not have the knowledge and skills to support people who used the service.

People were supported to have their nutritional needs met. However the dining experience on the unit for people living with a dementia need improvements.

The requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards [DoLS] were not always adhered to.

People were supported to access healthcare professionals and services.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were caring but due to lack of staff numbers did not respect people's privacy and dignity.

Staff knew people who used the service well.

Wherever possible independence was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.
People's needs were not always assessed and care plans were not person centred.

People were happy with the activities on offer.

A complaints and compliments process was in place. However not all complaints were recorded with an outcome to show the person making the complaint was happy

Is the service well-led?

Inadequate

The service was not well-led.
There was no manager in post on the second day of inspection.

Staff meetings did not take place regularly. Meetings for people who used the service and or their relatives did not take place.

Feedback for people's views was not sought.

Monthly quality monitoring reports took place by the area manager. However these did not highlight the issues found during inspection.

Wellburn House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 the 10 March 2016 and 7 April 2016 was unannounced.

The inspection team consisted of two adult social care inspectors, a pharmacy inspector, a CQC service delivery manager and three specialist professional advisors (SPA) A specialist professional advisor is someone who has a specialism in the service being inspected such as an occupational therapist.

Before our inspection, we reviewed the information we held about the home. We looked at statutory notifications that had been submitted by the home. Statutory notifications include information about important events which the registered provider is required to send us by law. This information was reviewed and used to assist us with our inspection.

The provider was not asked to complete a provider information return [PIR]. This 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.

During the visits we spoke with 13 people who used the service, three relatives, the manager, three area managers, the deputy manager, the administrator, the house keeper, the head cook, the maintenance man and eleven staff members. We undertook general observations and reviewed relevant records. These included nine people's care records,17 medicine records, four staff files and other relevant information such as policies and procedures.

Inadequate

Is the service safe?

Our findings

During our inspections in 2015 we found medicines were not managed safely. Staffing numbers at the service did not always reflect the level needed to meet people's needs, as identified by their own dependency tool. Recruitment procedures were not safe. Risks were not always appropriately assessed and action was not taken to ensure risks to people were reduced. Cleanliness and infection control procedures required attention especially in bathroom and toilet areas. Accidents and incidents were not monitored sufficiently by the acting manager to ensure any trends were identified and lessons learnt.

At this inspection we looked at how medicines were handled and found that the arrangements were not always safe.

Most of the people who used this service had their medicines given to them by the staff. We observed a senior carer giving people their medicines. They followed safe practices and treated people respectfully. People were given time and the appropriate support needed to take their medicines. One person was self-administering some of their medicines. However a risk assessment had not been undertaken to ensure they were safe to do so

Records relating to medication were not completed correctly placing people at risk of medication errors. Medicine stocks were not properly recorded when medicines were received into the home or when medicines were carried forward from the previous month. This is necessary so accurate records of medication are available and care workers can monitor when further medication would need to be ordered. For medicines with a choice of dose, the records did not always show how much medicine the person had been given at each dose.

Arrangements had been made to record the application of creams by care workers. However, these records were not always completed. This meant that it was not possible to tell whether creams were being used correctly.

When we checked a sample of medicines alongside the records for 17 people we found that medicines for 11 people did not match up so we could not be sure if people were having their medication administered correctly.

Two medicines for two people were not available. This meant that appropriate arrangements for ordering and obtaining people's prescribed medicines was failing, which increased the risk of harm to people.

We looked at the guidance the service had about medicines to be administered 'when required'. Although there were arrangements for recording this information we found this was not kept up to date and information was missing for some medicines. For example, one person was prescribed a medicine that could be used for agitation and anxiety. There was no care plan or guidance in place to assist care staff in their decision making about when it would be used. For another person the prescribed dose had changed but the guidance had not been updated to reflect this. This meant the registered provider did not have

appropriate guidance in place to ensure people were given their medicines in a safe, consistent and appropriate way.

Medicines were kept securely. Records were kept of room and fridge temperatures to ensure they were safely kept. We saw that eye drops for two people, with a short shelf life once opened, were still in use after the date recommended by the manufacturer. This meant that staff could not be sure this medicine was safe to administer.

Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Additional records were kept of the usage of controlled drugs so as to readily detect any loss.

We looked at how medicines were monitored and checked by managers to make sure they were being handled properly and that systems were safe. We were told that audits were completed regularly; however where issues had been identified no action had been taken by management. This meant that some issues we found during our visit had not been identified by the registered provider.

Risk assessments were not always completed or contradicted what was written in the care plan. One person had sustained numerous falls, one fall two days prior to inspection where they had sustained severe facial bruising. The persons care records were disorganised and in a document wallet rather than a file. The risk evaluation for falls was rated as moderate on the 17 January 2016 and the falls risk assessment completed on the 13 February 2016 rated the person with medium risk of falls. Between these dates, 17 January 2016 and 13 February 2016, the person had sustained numerous falls including a fractured elbow on the 19 January 2016. We discussed the lack of evaluation of risk with the manager.

One person who had been living at Wellburn since August 2015 had a Malnutrition Universal Screening Tool ('MUST') record completed on moving into the home with a recorded weight of 85.7Kg, overtime there had been a decline in weight to 75.0Kg. This had only recently been commented on in the MUST and highlighted for weekly weighing. Between October 2015 and November 2015 six kilogram was lost without comment in the MUST. This was highlighted to the manager at feedback. The manager said she was unaware of this and would look into it.

One person's care file we looked at had their surname spelt incorrectly. This could lead to a risk of incorrect care being provided. We discussed this with the manager.

On arrival at Wellburn it was initially confusing as to how many people were using the service. Staff indicated that there were 20 people on the first floor Dementia unit and 41 people on the ground floor area. The numbers on the notice board in the ground floor senior care assistant office indicated that the total number was 58. In the event of an emergency these conflicting numbers could prove problematic.

We saw evidence of Personal Emergency Evacuation Plans [PEEP] for all of the people living at the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. The service had an evacuation box with a 'grab' file to be used in the event of an emergency. This included the PEEPs, emergency equipment such as torches, batteries, pens etc, and a wristband for each person which should have had their name, date of birth and room number detailed, however these were blank. We found the file with the PEEPs documented did not match the people who lived at the service. A list of people was at the front of the file and their PEEPs behind this list. However further in the file another list was found. This could be confusing for someone who is not aware of the homes layout. The second list was for people living upstairs, this could easily be missed if someone just went by the first list in the file. Despite a daily checklist

on the evacuation box we found the torches needed batteries and spare batteries were not available. The booklet that staff were to sign to say all checked was blank. On the second day of inspection the area manager said that the evacuation box had all been sorted. However the list of people using the service was still separated and confusing.

We did see that fire evacuations took place to cover both day and night staff and we saw records to evidence this.

Accidents and incidents involving people and staff were recorded providing information about what happened and any actions taken at the time and subsequently. We found no evidence of analysis or trends highlights despite 46 falls being recorded. We discussed the lack of analysis with the manager.

We were made aware during an afternoon senior staff meeting that the service had issues with ants in a couple of rooms. Therefore we were concerned to find a dish containing what appeared to be an unused portion of sponge and custard left in a cupboard. We reported this to the manager and had it removed straight away. We saw that there was no single person responsible for the checking of wheelchairs or the cleanliness of slings (which had shared use) and in one room there was a wheelchair with food and wet tissue wedged next to the seat and a blue sling that was soiled. We also reported this to the manager.

These findings evidenced a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014

We looked at the arrangements that were in place for safeguarding vulnerable adults. The service had policies and procedures for safeguarding vulnerable adults, whistle blowing, accidents and incidents. We spoke with staff about safeguarding and we found they understood the different types of abuse, how to report, escalation of concerns and whistle blowing procedures. However staff were not confident that any safeguarding concerns raised would be dealt with appropriately. One staff member had passed a number of concerns onto the manager but nothing had been done about these concerns. We found that the manager was sharing incidents between people who used the service with the safeguarding team but not the concerns about staffing and medication practices. For example low staff numbers and medicine errors.

These findings evidenced a breach of Regulation 13 (Safeguarding people from abuse and improper treatment) Heath and Social Care Act (Regulated Activities) Regulations 2014

We noted that CQC had not been notified of the safeguarding incidents.

This is a breach of Regulation 18 (Notifications) of The Care Quality Commission (registration) Regulations 2009. This matter will be dealt with outside the inspection process.

We found people were cared for by un-sufficient numbers of suitably qualified, skilled and experienced staff. On the first day of inspection we questioned why people were left in their wheelchairs and we were concerned for one person who was falling asleep in their wheelchair and looked to be leaning out. Staff we spoke with said this person required two staff members and they were on their own. We highlighted this to the area managers who quickly arranged for staff from another unit to support this person. Staff we spoke with said, "One extra member of care staff per shift or even half a shift would provide the degree of flexibility required to organise better completion of tasks and provide more time to spend with the residents." Another staff member said, "We do not have enough staff and it was getting worse." And another staff member said, "We could really use an additional pair of hands when we are busy." And another said, "It's 4-15 pm and not one of us has had our lunch break yet." We fed this back to the manager who quickly dismissed it as untrue.

One staff member said, "On paper it looks like there is enough staff but that includes the manager and the deputy managers who do not help out on the floor." On the second day of inspection staff reported that staffing levels had improved.

One person who used the service said, "I have to drink plenty otherwise I get an infection, but don't want to drink too much as you can wait longer to go to the toilet, usually longer at changeover"

Staff were not receiving rotas in a timely manner; one staff member was going home and stating that they did not know when they were next on shift as there were no rotas. On the second day of inspection a four week rota had been implemented.

These findings evidenced a breach of Regulation 18 Staffing Heath and Social Care Act (Regulated Activities) Regulations 2014

We looked at the recruitment records for five members of staff. Recruitment and selection procedures were in place. However appropriate checks had not always been undertaken before staff began work for example we found gaps in employment not investigated, and queries from references not followed up. For example one person had provided their then employer as a reference, the reference came back stating, 'I do not remember this candidate.' The manager had not followed this up and had employed the person. We asked for this to be followed up during inspection and it was.

These findings evidenced a breach of Regulation 19 (Fit and proper person's employed) and schedule 3 of the Health and Social Care Act (Regulated Activities) Regulations 2014

We saw evidence that a Disclosure and Barring Service [DBS] check had been completed before they started work in the home. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults.

We saw safety checks and certificates that were all within the last twelve months for items that had been serviced and checked such as fire equipment, electrical safety and water temperature checks.

We saw that the service was clean and tidy and there was plenty of personal protection equipment [PPE] available. No unpleasant smells were encountered whilst walking around the service. Moving and handling hoists had been recently inspected and were labelled according to when their next inspections were due. We spoke with a member of the domestic team who stated that they had to follow a set daily cleaning rota for some areas and another schedule for areas that required less frequency. We observed them completing such cleaning duties. This staff member also said that there were now sufficient staff for the cleaning duties and that a new housekeeper had been recently employed.

Inadequate

Is the service effective?

Our findings

At our last inspection we found that people were being deprived of their liberty without lawful authority.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Discussion with the deputy manager, and administrator indicated that 45 people at Wellburn were subject to DoLS. However we found that this was incorrect and 14 DoLS had been authorised but two had expired and a further 21 had been applied for in early 2015 but never chased up.

On the first day we found that the folders where the DoLS information were stored were chaotic and it was impossible to readily determine who had an authorised DoLS in place. There were applications and authorisations in the folder for people who were no longer using the service and no evidence to show when or how the applications were being pursued. The majority of applications were sent mid 2015 but not as yet authorised. No consideration had been given to the fact that staff practices were depriving people of the liberty and until a DoLS authorisation was in place this was illegal. This was no different from what we had found in the July 2015 inspection.

On the second day of the inspection the area manager told us they had organised the folders into those applications that were not yet approved and authorised DoLS. When we reviewed the folders this was not the case and the information remained jumbled. The area manager told us they had requested a full list from the supervisory body of who had a DoLS authorisation in place but that had yet to be received. They confirmed that they could not tell us exactly who had a valid authorisation in place.

Again staff were not aware that people had the right to challenge DoLS authorisations at the Court of Protection and therefore did not enable people to get representation

These findings evidenced a breach of Regulation 13 (5) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014

There was evidence of some mental capacity assessments in care files, although it was unclear from the records reviewed as to the extent of capacity that the individuals had. Records referred to individual's families making decisions in relation to more complex decisions. However there was no evidence of a process being involved to determine this, or clarification as to what more complex decisions were. There was conflicting information on the mental capacity assessments and the relevant decisions were not always recorded.

During this inspection we did not see evidence of consent to care and treatment records being signed by people where they were able, in all care files. A 'Client Agreement Form' for one person's consent to various care plans did not tally with the actual care plans in their file.

Again we found no evidence to show that staff checked whether family had any legal authority such as lasting power of attorney care and welfare prior to asking them to make decisions on behalf of the person or sign care plans.

These findings evidenced a breach of Regulation 11 (Need for consent) of the Health and Social Care Act (Regulated Activities) Regulations 2014

We were provided with a training matrix. This matrix showed that staff had not received the required training. 17 out of 69 staff had received basic life support, 18 staff out of 69 had received food safety. 26 staff out of 69 had received infection control. 33 staff out of 69 had received training in MCA and DoLS, 29 staff out of 69 had received safeguarding training and only 6 staff had received safe administration in medicines training. We discussed the lack of training with the manager who stated that they were finding it difficult to get staff to come in for training. The manager also pointed out new notices displayed in the office that staff will be disciplined if they did not turn up for required training.

We looked at the induction process new staff received. We saw one member of staff was working unsupervised and had received no training other than a medicine competency assessment. We discussed this with the area manager who informed us that this member of staff was asked to attend training for manual handling on the 17 February 2016 and they did not attend. The then manager still allowed the staff member to work unsupervised. The area manager said training had now been booked in and the member of staff was now working under supervision. We were told new starters had to complete two days of induction, one day for paperwork and one day shadowing experienced members of staff. We looked at people's induction records. During induction the new staff member had 74 sections to cover, these included policies, tour of building, introduction to people who used the service, inspection reports, assessing care records, all information to do with staff such as wages, meetings, supervisions, hours and leave, health and safety and quality assurance. We saw that every new starter had completed all 74 sections in one day and the manager had signed them off. We discussed this lack of effective induction with the area manager who agreed it would not be possible to complete all 74 sections in one day.

Staff were not receiving support through regular supervision and appraisals. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff.

These findings evidenced a breach of Regulation 18 (Staffing) of the Health and Social Care Act (Regulated Activities) Regulations 2014

At our last inspection we made a recommendation that the registered provider looks at the dining experience for people who used the service.

There was a small four week menu plan on display outside the downstairs lounge. We asked staff what week it was to see what was for lunch that day, no one knew. We asked the manager and they also did not know. We questioned how people who used the service would know but no one could answer.

We observed a lunchtime meal in all three dining rooms. The small downstairs dining room people were offered just one meal a roast chicken dinner, but a choice of what vegetables they wanted. One person only wanted cereal and this was provided.

In the main downstairs dining room we saw staff bring one person who used the service into the dining room for lunch in a wheelchair. Two carers tried to transfer the person from the wheelchair to the dining room chair. The carers were unable to lift the person and made a decision to leave the them in the wheelchair. The carers moved the person towards the table, but not far enough in for them to properly reach their plate. We saw the person pulled the plate half off the table to try and eat. Due to the difficulty in eating, they ate one potato and the meal was taken away.

Another person came to lunch in a wheel chair and the two same carers brought the hoist and assisted the person so that they were able to sit in a dining room chair and eat lunch. We asked the manager why the hoist could not have been used for the other person but no explanation was provided. One person did not eat lunch and the carer asked if they would like a jam and bread sandwich instead, and this was brought to the person.

People were not asked what they would like to drink; orange juice was automatically served with no alternative. The door constantly slammed between the dining room and the kitchen and one person made comment and said this was usual when we asked. Another person asked what the pudding was; the person had to ask three different members of staff before being told 'cake and custard,' it was 'pineapple upside down pudding and custard.' We saw people were not provided with a choice and everything was served up on the plate. One person said, "They always give me stuffing, I do not like it." One person was served pudding, it was left uneaten and they said they did not want the pudding and ice cream was offered. This same pudding was then moved to another person to eat.

Upstairs on the unit for people living with dementia. 18 people had lunch in the dining room. People began to be shown to the tables at 12.00 however serving did not begin until 13.00 hours. This led to some frustration and agitation amongst the people sitting at table. Several people wandered out during the intervening time. Tables were laid simply with cutlery and orange acrylic mugs, no condiments. The menu board for the day was blank. Three members of staff were involved in serving lunch, however the process was disorganised with some people left waiting for their meal for some time, whilst others who required support were given theirs first, and then left until a member of staff was available to assist them. One person requested salt and pepper. Some salt was found, although no pepper was found, and no further offer to find it was made. Upstairs people were served their food on orange acrylic crockery which the manager said was designed for people with a dementia and safer if thrown. This meant people were not receiving a personalised and dignified approach to their needs. We discussed this during feedback and the area managers said they would source more appropriate crockery.

We saw one staff member asking people at 11am what they would like for lunch the following day, scampi. We discussed this with the manager, stating this could confuse people especially since they had not had their lunch that day as yet. The manager said the staff member was asking for that day's tea request. However we were still there at teatime and tea was a 'party tea' sandwiches and cakes etc. The next day was scampi.

We saw a cupboard in the upstairs dining room where there were numerous plastic containers with different breakfast cereals in them, none of which were labelled in respect of their contents, neither were they dated as to when they were last replenished. This meant that new cereal could be poured in over existing cereal and we could not establish how long the cereal at the bottom of the container had been there for.

We spoke with the chef who had worked at the service for 10 years and indicated a good understanding, and had good systems in place regarding the catering requirements. The Chef received a weekly update of people at Wellburn and their specific needs in relation to diet type, such as diabetic or pureed. No ethnic or

other diets were requested, although if required these could be prepared or bought in such as Halal or Kosher. The service had recently been inspected by the local authority and awarded a level 5 for food hygiene.

The chef had a range of up to date information sheets available for reference in relation to Diabetes / Dysphagia / and other specialist food requirements. Discussion regarding whether visiting specialist advisors e.g. Dieticians or Speech and Language Therapists (SALT) met with the chef during assessment of individuals indicated that they did not. This is something the chef found frustrating as they received information via care staff and was something they felt they could contribute to the discussion.

A four week rolling menu programme was in place, the chef reported that one main course was prepared and that people were offered a range of alternatives (Omelette / Salad/ Sandwiches/ Baked Potato) if they wished an alternative. The chef said this reduced wastage from producing two main dishes.

We asked people what they thought of the food. One person said, "I like the food, I eat every bit." Another person said, "Food is nice I cannot complain." And another person said, "The food is all very nice what we have but I would like more fruit." One person we spoke with said ""Food is not what I like, usually some type of casserole, we always have fish on a Friday and I don't like either, if I do not like the food, they will make me a sandwich instead." Another person said, "I have asked for smaller portion sizes, but told eat what you can, it is in your face and too much." And another person said "I don't like the orange juice but no alternative."

The meant the mealtimes did not support a dignified experience for all people using the service.

These findings evidenced a breach of Regulation 14 (Nutrition and hydration) of the Health and Social Care Act (Regulated Activities) Regulations 2014

We were told that one of the bathrooms and a shower room upstairs was out of use and one on the ground floor also. A member of staff said (of the ground floor bathroom) 'It's been reported to our estates several time but it has still not been fixed'. Another member of staff said "We're having to use the bathroom in the empty wing but it's cold in there, there's no heating on. It also takes two members of staff off the floor when we bathe someone using this bathroom." We discussed this with the manager who said it had been reported.

These findings evidenced a breach of Regulation 15 Premises and equipment and Social Care Act (Regulated Activities) Regulations 2014

We saw evidence of involvement of other health and social care professionals involved in care, for example General Practitioners (GPs), social workers, safeguarding team, dietician, speech and language team (SALT), and district nurses. On the day of inspection an ICLS (Intensive community liaison team) healthcare professional visited and said they get a lot of referrals. They also said, "My team is usually called in when a resident's behaviour changes or we are asked to review someone's medication. We do routine reviews of residents' medication."

Requires Improvement

Is the service caring?

Our findings

We asked people who used the service if they thought the staff to be caring. People we spoke with said "The staff are very good and helpful." Another person said, "they (the staff) will do anything for you." And another person said "They have a hard job." Other comments included, "When I ring for the buzzer, the staff come, but then have to wait as they are usually tending to other people." And another person said, "The buzzer goes 12 times, sometimes14 to 15, I tell them to shut up."

Relatives reported that they were very satisfied with the care their relative received. Relatives praised the staff and their response to the people who used the service's needs. One relative we spoke with said, "My relative appears to be well cared for." Another relative we spoke with said "The staff are good and look after (my relative) but are really busy." And another relative said "I do not think that the residents are always spoken to kindly I have witnessed staff speaking very abruptly to residents when they don't realise I am there." We provided the manager with these comments and they said they would look into it.

A member of staff said "We do not have time to sit with the residents, there's no 'in-between time' to allow this." Staff on the ground floor were generally noted to be busy, and some people were left sitting in the lounge area with little in the way of stimulation. People were left in their wheelchairs for long periods of time. In the small downstairs lounge the television was turned up really high making people shout at each other. People who used the service made comments about how loud things were.

We found on the first day one member of staff was supporting 17 people and this had led to people being left in wheelchairs for long periods of time. During the afternoon of the first inspection day one person was falling asleep in their wheelchair and leaning forward. We were concerned the lady would fall out and asked a member of staff why they were left in a wheelchair. The staff member said, "She is a two person lift and I am on my own." An area manager visiting that day quickly arranged another member of staff to support. Also at meal times the sole staff member was unable to support people with their meals. We found that this had been a consistent issue.

These findings evidenced a breach of Regulation 18 Staffing Heath and Social Care Act (Regulated Activities) Regulations 2014

Staff interaction with people around the home was good; this includes ancillary staff as well as direct care staff.

We observed staff to treat people with dignity and respect for example, a member of staff went over and addressed a person who used the service by their name, asking how they were. From the conversation which followed the member of staff was talking to the person about their family, remembering their names, and treat the person as an individual with respect and dignity.

We saw staff demonstrated an understanding of good practice in relation to respect, dignity and completion of personal care tasks. We were shown a wall chart which had resulted from a "Dignity Day" where people

who used the service expressed what dignity meant to them.

We observed staff support one person was in unexpected difficulty whilst using the toilet. The staff member discreetly attended, demonstrating respect for the dignity of the person.

Staff were patient, kind and polite with people who used the service and their relatives. Staff clearly demonstrated that they knew people well, their life histories and their likes and dislikes and were able to describe people's care preferences and routines. Overall, people looked clean, comfortable and well cared for, with evidence that personal care had been attended to and individual needs respected. □

At the time of inspection no-one was receiving end of life care, although discussion with a senior carer indicated a good understanding of aspects of end of life care. Review of the care records of one person who used the service indicated that 'end of life care' had been omitted from the plan of care on admission, although 8 months later the subject was yet to be discussed with the individual and their family. Despite the person having multiple cardiac and respiratory problems.

Information on advocates was available; however nobody was using an advocate at the time of the inspection. Advocates help to ensure that people's views and preferences are heard.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we made a recommendation that the registered provider looks care plans to make them more person centred and to ensure people are involved in the care plan development and review where they are able.

During this inspection we looked at 11 care records. The majority of care records are kept in individual A4 ring binders, stored in a lockable cupboard / filing cabinet in the senior carer's offices. Daily Cate records are kept in separate plastic folders in the office. It was noted that some care records were kept in document wallets, which led to them being disorganised.

There was evidence of a management audit undertaken in February 2016 in one folder; this highlighted a number of omissions, including a missing identification photograph. A week had been identified to action these omissions. This had not been completed.

Personal information was detailed and up to date, with details of next of kin, contact numbers and details of professionals involved. However, in one care file the person's surname was spelt incorrectly. The care files we looked at were not all person centred. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person. People's choices and wishes were blank. The agreement forms to what was detailed in the care plans were not all signed.

There was no evidence in the records seen of the involvement of the individual or family in review of the care plans. One visitor we spoke with said, "I have never had any conversations with the staff about (my relative)."

A personal care plan for people's individual daily needs such as mobility, personal hygiene, sleep and night care had been documented in some files on admission. However one person's mobility care plan was confusing as it said needs a hoist for transfer on one page and then uses a stand aid on another page. We provided the manager with all this information.

Daily notes were kept separately for each person with recordings regarding their basic care, how they had been that day and any updates, although there was a tendency to be repetitive in parts whilst recording people's activities over the day and any specific interventions.

Charts to evidence that people had received any highlighted hourly observations, checks or two hourly turns had not been completed. On our second inspection the area manager had introduced a new daily form which staff had to complete to evidence personal care, nutrition intake, checks, turns and observations. We asked staff who would be on two hourly turns throughout the night, two names were provided and we saw that these charts had not been completed by the night staff. We discussed this with the area manager who said they would make sure everyone was told again how to complete the forms. The forms had only been in use for five days, but were to be audited weekly.

We noted that staff did not take into consideration the impact on people of having televisions at full volume.

The staff told us that one person was hard of hearing so liked the television in the lounge set at full volume. We asked why a hearing loop or subtitles were not used and they could not tell us. We observed that this high level of noise led to other people shouting at each other to be heard and this generated an atmosphere of unrest and agitation.

These findings evidenced a breach of Regulation 9 Person-centred care Social Care Act (Regulated Activities) Regulations 2014

People were provided with choice, such as where they wanted to sit, spend their day, clothes they want to wear. Some people got chatting to one person and would join them for meals while others preferred to stay in their rooms.

There are dedicated activities coordinators for the home. There was evidence on the walls of different displays that people who used the service had been involved in making. On the first day of inspection 19 people were involved with the activities coordinators, as well as a relative. They were doing egg decorating session. This was a particularly lively and well organised session, in which everyone participated. All decorated eggs were on display in the reception area afterwards. Staff advised that people from the upstairs unit had been taken downstairs to join in the activities.
One relative said, "(My relative) really enjoyed joining in the activities they organised." A person who used the service said, "There are lots of activities which I like, dominoes, singer and today the Easter egg competition."

We looked at the service's complaint's procedure. During our first inspection we could see one complaint had been documented but there was nothing recorded to say what had been done about the complaint. On the second day of inspection we saw the service had received a further two complaints. The area manager had documented what the complaint was, what had happened about the complaint and the outcome of the complaint.

We spoke with one person who provided a very clear account of their admission experience and subsequent life at Wellburn House. They reported that they felt well cared for and had come to realise that they could not look after themselves at home any more. They were quietly reading a book in their room and said that the maintenance man was helping them to set up their television. They said, "I am free to move around the unit and I am happy with the range of activities and feel involved."

Inadequate

Is the service well-led?

Our findings

On the first day of inspection there was a manager who had worked at the service since October 2015 and was going through the registration process with the Care Quality Commission. The manager was supported by two deputy managers. It was unclear on the first day of inspection what the specific roles of the deputy managers were; One deputy said, "We support to the manager role." On our second day of inspection this manager had left the service and the area manager was managing Wellburn until a new manager could be appointed.

On the first day of inspection we asked staff if they felt supported by their manager. Staff we spoke with said, that they thought that management was approachable but were less confident about their effectiveness to resolve issues. One staff member said, "I provide the manager with a list of all concerns I find during the day, but nothing gets done with them, I photocopy the list before I give it to the manager now so I have my own proof."

Other staff members said that team leaders do not generally assist with people but remain in the office working on paperwork and additionally complete medication management tasks.

On the second day of inspection staff we spoke with said, "Oh we get clear guidance now, I am a lot happier." Another staff member said, "Things have totally improved, it is such a better place to work now, very happy."

The service completed some audits. A medication audit was completed on a monthly basis, however only two recent audits were completed correctly as they had percentage scores given. The most recent February 2016 being 90% which 'failed' and a number of issues highlighted but no issues addressed. An Infection Control audit was up to date; however it was unclear as to whether actions highlighted were actioned. Kitchen audits were up to date, and detailed in actions required, although some management actions remained outstanding. The last health and safety audit that we were able to find was October 2015; this was highlighted to the manager.

The area manager carried out monthly quality monitoring reports. These reports did not highlight any issues or concerns we found during inspection. For example, the February report stated good standards of documentation for medicines. Where we found records relating to medication were not completed correctly placing people at risk of medication errors. Another comment stated that there was ample choices at meal times, where we found people only had one choice unless they specifically asked for something else.

In contrast to the area manager's monitoring reports the registered provider compliance team had completed an audit. We saw that this highlighted all of the issues we noted at the inspection in July 2015. This audit demonstrated that no improvements had been made but the area manager was adamant that the home was demonstrably improved.

We were told that the registered provider had sent out a survey questionnaire to seek people's feedback.

The forms were not available to us during inspection. No other feedback had been sought since our last inspection.

These findings evidenced a breach of Regulation 17 Good governance and Social Care Act (Regulated Activities) Regulations 2014

We saw records to confirm that two general staff meeting and one senior staff meeting had taken place since our last inspection. On the first day of inspection a senior staff meeting took place, however there was no record of this on our second day. The general staff meeting took place on the 24 March 2016, topics discussed were feedback from our first day of inspection, accident monitoring, communication, training (non-attendance), and the dining room experience. For the senior staff meeting the same topics were discussed as well as leadership, medication, care plans and DoLS and MCA procedures. One inspector sat in on the senior meeting on the first day of inspection. Topics discussed were smoking breaks, care plans, mobile phones and too many errors in medicines.

We saw evidence of two meetings for people who used the service which took place on the 11 December 2016 where the garden was discussed and another meeting on the 9 March 2015 where activities and food was discussed. People at this meeting also stated that they were happy.
One person who used the service said, "We have just had a meeting, I encourage people to attend. I express my views and feel heard by staff."

The law requires providers send notifications of changes, events or incidents at the home to the Care Quality Commission. At the first inspection we noted that the manager had not complied with this regulation. The area manager back dated notifications to CQC.

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 did not take formal enforcement action at this stage. 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 manager was not notifying CQC of safeguarding matters and significant events.