Trafford Council

Waterside House

Inspection report

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29 October 2020

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Waterside House is a supported living service providing personal care to people aged 18 and over with learning disabilities and/or autism provided by Trafford Metropolitan Borough Council. The supported living service provides supported accommodation to 22 people in seven supported living accommodation properties.

People's experience of using this service and what we found
Safeguarding processes were not effective, and people were put at potential risk of harm due to the poor management of safeguarding concerns. There had been some safeguarding events at the service which had prompted us to inspect. As a result of the number of safeguarding allegations the commissioners have placed Waterside House in a temporary suspension of new admissions to the service.

The provider's initial response to concerns raised has provided a level of assurance. We have been provided with an extensive action plan following our inspection, where the provider in some cases has taken immediate action.

The provider's incident management policies and procedures were not routinely followed. Opportunities to learn from incidents were missed, due to a lack of reporting systems in place. There was a closed culture where staff were reluctant to use the provider's whistle blowing procedure.

One of the supported living settings we visited we found two potential hazards to the environment. Risk assessments concerning these environmental risks had not been completed to minimise risks to people.

The providers approach to COVID-19 was inconsistent. The risk to staff and people using the service from COVID-19 had not been adequately assessed in a timely manner, with measures introduced to reduce the risk. The use of face masks to be worn by staff had only recently been introduced and key internal policies and procedures had not been devised in a timely manner to support to prevention of COVID-19 entering people's homes. Shortly after the inspection safe systems were implemented.

The management of the service was not cohesive. The organisational structure was not followed, and reporting lines were unclear. Systems were disorganised and audits we requested had not been forthcoming in a timely manner due to this. The service was unable to demonstrate any analysis of themes and trends or how learning was shared with the staff team to ensure continuous improvement. The provider was looking to recruit a quality assurance manager that would support the service with the necessary improvements.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. There was a poor staff culture within a small number of the supported living settings which meant people were vulnerable to the risk of safeguarding incidents. Whilst the management team had completed some investigations into concerns about this culture, not all allegations were investigated appropriately or reported to the senior management team.

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

Rating at last inspection
The rating at the last inspection was good, the report was published on 6 December 2019. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Waterside House on our website at www.cqc.org.uk.

Why we inspected
The provider contacted us to state they had raised several safeguarding concerns, some of which had not been reported in a timely manner. As a result, we undertook a focussed inspection to review the key questions of safe and well-led only.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

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 how the service is managed, how safe people are at this service, and staff knowledge and practice.

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 requested an action plan from the provider, which was promptly provided and detailed 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service.

This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Waterside House

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 three inspectors and an expert by experience. An expert by experience telephoned people and their relatives who received a service from Waterside House on 22 October 2020. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service provides care and support to people living in 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, at the time of inspection the registered manager was not available for work.

Notice of inspection
We gave one-hour notice so we could clarify the services COVID-19 Personal Protective Equipment (PPE) practice for visiting professionals and identify persons who were shielding so we could respond accordingly.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authorities with whom the service works. On this occasion the provider was not asked to complete a provider information return prior to this inspection. This is information we require providers 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.

During the inspection
Due to the national pandemic we completed a focussed inspection therefore reducing the time we spent at the service. We spoke with four people at the two supported living properties we visited. We spoke by telephone with three people and eight people's relatives who used the service. During the inspection we spoke with the interim manager, the strategic lead, two team leaders and eight support workers.

We reviewed a range of records. We reviewed some of the documentation remotely by asking the provider to send us key information prior to meeting with them. We reviewed two people's risk assessments and multiple health and safety records. We looked at one staff record in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance records.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. 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.

Systems and processes to safeguard people from the risk of abuse
• People had not been sufficiently safeguarded against the risk of abuse. Not all allegations of abuse made to the provider had been investigated or referred to the local authority safeguarding team. The CQC are currently liaising with the police and local safeguarding authority while these matters are being investigated.

• The management team failed to ensure people were protected from allegations of abuse. They had failed to share information with members of the senior management team and safeguarding authority about a number of safeguarding and whistle-blowing incidents made direct to them. This meant overarching safeguarding assurance systems were ineffective.
• There was a negative culture in some of the supported living settings where staff did not always treat people with respect. The provider was taking action to address the cultural issues within the service.
• Although the staff team had received training in safeguarding adults, we found a number of staff had not safely followed safeguarding processes and we noted some members of staff were due a refresher in this subject. The provider has given us high level assurances that safeguarding training is under review and will be revamped as a priority.
• During the inspection we found one person had an unexplained injury. It was clear this matter has not been escalated correctly, which meant a prompt safeguarding referral had not been made. A referral was made once we prompted the service and the person received additional medical treatment.
• The management team could not demonstrate how they looked for themes and trends in safeguarding concerns or how they mitigated the risk of re-occurrence. During the inspection we noted one medication error in May 2020 was noted in a communication book, this had not been reported to the safeguarding authority in a timely manner.

The above meant systems and processes were not established and operating effectively to prevent potential abuse, placing people at risk of harm. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong, Preventing and controlling infection
• At one of the supported living settings we visited, we identified two health and safety concerns to the outdoor decking area being in disrepair and access for one person to leave the home was impacted due to a high step at the entrance of the home. The provider has acted swiftly once we raised this further with them, with further escalation to the housing association and newly implemented specific environmental risk

assessments.
• At the time of inspection, the provider did not have any infection control audits in place or an infection prevention and control lead within the service. This meant there were no checks of the environment or staff practices recorded, which did not follow good practice as outlined by Public Health England.
• The provider did not have a policy and procedure in place to manage the risks of COVID-19, however we were provided with high level assurances a policy would soon be implemented along with a number of improvements connected to the prevention of COVID-19.
• During the inspection we were provided with general service risk assessments for COVID-19 last completed in April 2020. However, we found the service failed to complete individual risk assessments for vulnerable people using the service or staff members who may be at higher risk during the COVID-19 pandemic.
• Staff had not received any up to date infection control training to reflect COVID-19. Staff we spoke with confirmed they had not received any training but received information about government guidelines.
•Three days prior to our inspection visit the local commissioning team visited one of the supported living services and noted staff were not wearing face mask. Subsequently, face masks were introduced for all staff members, this meant face masks had not been worn for several months and was another indication the provider was not fully equipped to respond to the pandemic.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a new breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• As a result of the failures noted in response to the pandemic, the provider has implemented a detailed action plan with clear timescales.
• All supported living services are due to have visiting pods installed in line with Public Health England guidance. Digital technology such as laptops was being rolled out to all of the houses to promote effective communication between people and their families.
• Infection, prevention and control training was also due to be rolled out to the staff team. The provider implemented a procedure for the supported living service around COVID-19. Testing of COVID-19 has also become available for people and staff members.

Learning lessons when things go wrong
• There were no arrangements for ensuring learning from incidents or when things went wrong. Opportunities for improving and mitigating risks were not taken.
• There was no evidence to demonstrate learning from safeguarding concerns or of action taken to prevent re-occurrence and keep people safe.
• The provider has highlighted in their action plan a newly developed monitoring system will be introduced to provider greater oversight of incidents. We will review the progress of this at our next inspection.

Staffing and recruitment
• Robust recruitment processes were in place and staff followed these to ensure only suitable people were employed. People told us they liked the staff.
• Staffing levels were appropriate to meet the needs of the people using the service. Sufficient staff were available to meet people's needs promptly throughout our visits to two supported living settings.
• Feedback from staff in relation to staffing levels was generally positive, but one staff member told us one supported living setting heavily relied on agency staff. We discussed this area further with the interim manager and strategic lead who accepted the deployment of staff is currently being reviewed for greater continuity of care.
• The Public health England guidance for preventing the spread of COVID-19 states, "Sharing staff between

settings should be avoided to reduce the potential spread of COVID-19 from one setting to another." The provider has assured us they are in the process of reviewing staff deployment at the service and where possible will look to block book agency cover, to minimise agency staff working at other properties.

Using medicines safely

• Prior to our inspection we attended a safeguarding strategy meeting, this highlighted there had been two medicines discrepancies that had not been reported correctly to the safeguarding authority or CQC. We also found during the inspection three medicines errors had not been appropriately reported or investigated. It is clear improvements are needed to the escalation of medicines errors to drive improvement and improve transparency at the service. • People received their medicines as prescribed. Medicines administration records and 'as required' protocols had been updated to ensure they reflected current prescriptions and recommendations. We completed a stock check at two supported living settings and found these were all correct.

• Systems for checking medicines practices were in place. This included medicines counts, weekly in-house audits, staff training and competency checks.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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
• The management team did not demonstrate their understanding of quality performance and regulatory requirements. While there were established systems in place to monitor quality and to assist in complying with regulations, they had not been effective. We noted many audits connected to training and development, health and safety, medicines and risk management had not been completed for several months.
• It was clear there had been instances of poor and unsafe practices that were not reviewed or escalated to senior management, which resulted in a significant deterioration in the standards of care provided. Staff had not been provided with robust and responsive leadership by the registered manager.
• The provider did not have adequate oversight of the service. We found the provider did not undertake any compliance audits of the service.
• Systems for learning from incidents and near misses had not been implemented. This led to repeated themes of people experiencing poor care and inappropriate treatment from others.
• As a result of the shortfalls identified the provider has provided us with high level assurances the service will undergo a number of key changes and a timely action plan was introduced to support these improvements.

The provider did not have robust processes in place to ensure the safety and quality of the service was adequately monitored and improved, and to ensure known risks were acted upon. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• We found in some of the supported living settings a closed culture had formed, which did not promote the provision of high-quality, person-centred care and transparency.
• Allegations have been made against a small number of staffs conduct. It is clear some of these alleged practices when reported were not challenged or investigated by members of the management team. Subsequently the provider has responded appropriately, with a small group of staff no longer working at the service, pending investigation.
• There was a lack of oversight to ensure that notifications were made to the CQC. The registered manager had not notified the CQC of events that occurred. Notifications are required by law to ensure the CQC can monitor the service and ensure people are receiving safe care. This will be dealt with outside of the

inspection process. We will be discussing this possible breach with the provider.

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, engaging and involving people using the service, the public and staff, fully considering
• Prior to our inspection we found not enough action had been taken to address the allegations of a poor culture in a small number of the support living settings.
• Since the provider has become aware of these alleged concerns, they have worked hard to ensure people receive a safe and compassionate service. They have done this by completing a root cause analysis of the service, which has created an in-depth action plan.
•The provider accepted the culture within the service needs to be challenged and from the providers action plan there are multiple workstreams ongoing to support this change. This includes bringing in a new quality assurance manager role and an experienced social worker has been appointed to review the providers polices and procures at Waterside House.
• During the inspection we received positive comments from people and relatives about the service. Comments from people included, "I am very happy here and I like the staff." Comments from people's relatives included, "They [support workers] understand [person's name]. They know the signs to look out for", "The time they [support workers] spend with the residents is excellent. The fact that nobody in the residence has had COVID-19 deserves a big pat on the back" and "It feels like a home, not like an institution."

Working in partnership with others
•The service worked effectively with partner agencies. We spoke with a commissioning organisation who provided us with an action plan that had been devised in 2019. The service was also able to access support from the local community learning disability team.
• Family members were engaged and involved in people's care and updates about the service through telephone discussions and emails during the COVID-19 pandemic. Comments from people's relatives included, "It works completely. Emails, phone… no issues" and "I ring at the same time every week to check [person's name]. They [support workers] don't ring you unless there's majorly a problem, so not if it's a tummy ache."

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 12 HSCA RA Regulations 2014 Safe care and treatment We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. The provider failed to ensure people were protected from the risk of infection, including the transmission of COVID-19. Regulation 12 (1) (2 a, b and h)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established and operating effectively to prevent potential abuse, placing people at risk of harm. Regulation 13 (1), (2), (3), (6 a and b)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have robust processes in place to ensure the safety and quality of the service was adequately monitored and improved, and to ensure known risks were acted upon. Regulation 17 (1) and (2)

The enforcement action we took:

Warning notice