Waterloo House Rest Home Limited

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Inspection report

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Date of inspection visit:
20 June 2018
21 June 2018

Date of publication:
29 August 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 20 and 21 June 2018 and was unannounced. This meant the provider and staff did not know we would be coming.

We previously inspected Waterloo House Rest Home in May 2017, at which time the service was meeting all regulatory standards and rated good. The service was rated requires improvement at this inspection.

The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk and the accuracy of care planning documentation. This inspection examined those risks.

Waterloo House 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.

Waterloo House accommodates a maximum of 41 people across two floors. Nursing care is not provided. There were 36 people using the service at the time of our inspection, some of whom were living with dementia.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

There was a lack of managerial oversight with a range of audits either not being completed or failing to identify longstanding areas of concern. We could not talk to the registered manager at the time of inspection. The deputy manager had a good knowledge of people's care needs but did not have oversight of the management structures in place. The service was lacking direction and at risk of further deterioration due to this lack of direction.

The external consultancy firm who had been completing twice monthly visits had not identified the majority of the issues we saw on inspection.

There was a lack of analysis of when things went wrong in order to learn from these incidents and make improvements.

Risk assessments and care plans were often out of date or inaccurate, putting residents at risk. The fact that people received care from a well-established and knowledgeable care staff team meant they had not suffered significant impacts due to this lack of governance.

There were a number of instances of minor poor practice identified regarding medicines administration. These had never been identified or improved upon by the provider because there were inadequate auditing procedures in place.

Staff felt supported by their peers but staff meetings (and resident/relative meetings) had not happened for some time. There was insufficient staffing in place at the time of inspection to effectively meet people's needs and ensure compliance with the regulations. A dependency tool had not identified the need for increased staffing despite people's needs becoming more complex.

There were sufficient cleaning staff on duty but their hours of work needed reviewing as care staff were responsible for maintain cleanliness of the premises from 2pm onwards, which had a further impact on their ability to meet people's needs.

The service did not have an effective training matrix in place and training records demonstrated a lack of Mental Capacity Act/DoLs training. Likewise, ancillary staff such as cleaners and laundry staff would benefit from dementia awareness training. We have made a recommendation about this.

We could not be assured that people were always supported to have maximum choice and control of their lives in the least restrictive way possible because the relevant documentation was either not available or out of date.

There were adequate bathing and toileting facilities in place. Other areas of the building required improvement or were not properly utilised, such as a large lounge, the manager's office, and the outdoor space. Some equipment, such as the hoist and the sling, needed updating.

Care plans were sometimes brief although most we reviewed contained sufficient evidence for staff to know people's basic needs. Staff knowledge of people's needs was good and there were well documented interactions with external healthcare professionals.

Staff supervisions and appraisals had previously taken place but these had fallen away in 2018.

People had a choice of meals and gave positive feedback about levels of choice and range of food. Mealtimes we somewhat task focussed due to the pressures on kitchen staff but people did enjoy the meals.

People who used the service, their relatives and external professionals gave consistently excellent feedback about staff attitudes, patience, and commitment towards all people who used the service. The provider however had not given staff adequate time or support to provide care in a sufficiently patient and personalised way.

There was a strong consensus of opinion that the efforts, knowledge and passion of staff were the single biggest reason relatives and professionals would recommend the service. At the time of inspection, this passion and effort was not being adequately supported by the systems, process and upkeep of the premises and equipment by the provider.

We received exceptional feedback regarding how well staff supported people at the end of their lives, in

conjunction with district nurses.

People's changing needs more generally were not always accurately documented. Monthly reviews of care plans were in place but these appeared limited and had not identified the need to more comprehensively review people's care needs, for example if someone had been suffering a high number of falls and may need new equipment or a different care plan.

Activities provision was not effective as the activities coordinator was only scheduled to work in that area for 21 hours per week. This was insufficient given people's needs. Furthermore, the activities coordinator regularly helped with care tasks, detracting from the amount of time they had to plan and deliver activities. Information regarding people's individualities, life histories and preferences were inconsistent and not always accurate. We have made a recommendation about this.

There was no evidence of the provider ensuring staff were aware of recent best practice and links with external agencies to ensure practice improvement was limited.

The culture remained one focussed on caring for people in a dignified, personalised way, but this was largely down to the passion of the care team and not the provider, who needed to make a range of improvements to service provision.

We have identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

Risks were not well assessed, documented or analysed to identify trends or patterns, and to stop similar risks occurring in the future.

Staffing levels were not sufficient and a dependency tool had not been effectively used to identify what required staffing levels should be.

Medicines administration was not suitably reviewed or audited and there were areas of poor practice that needed addressing.

Pre-employment checks were not always robust.

People who used the service told us they felt safe and external professionals had confidence in the ability of care staff to keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

The premises had not been adequately improved in light of a previous CQC recommendation and assurances from the provider. Some equipment, such as the hoist and slings, needed updating.

Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training had not been effectively delivered and people's capacity was not always appropriately assessed.

Involvement from a range of external healthcare professionals was apparent and documentation in this regard was clear.

People enjoyed the meals on offer, although mealtimes were somewhat task focussed and the kitchen was understaffed.

Is the service caring?

Requires Improvement

The service was not always caring.

People who used the service, relatives and external professionals were in agreement that, despite the constraints placed on them, staff went above and beyond to ensure people received dedicated, compassionate care.

People interacted calmly with staff they had known for a number of years, meaning they received a continuity of care.

The service had a welcoming atmosphere and people who used the service considered it home. However, the provider had not always ensured that the service provided a caring environment because of their lack of oversight. They had failed to support staff adequately to give people the patient and personalised care they needed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were not always accurate or contemporaneous and presented potential risks to staff who did not have an in-depth knowledge of people's needs.

External professionals provided exceptional feedback about how well staff worked with external nurses to ensure people's end of life care wishes could be supported.

Whilst ad hoc activities took place regularly, these were not person-centred or meaningfully planned as the activities coordinator did not have sufficient time or support to do so.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of effective oversight of core processes such as medicines administration and risk assessments, meaning people were put at risk.

Formal support for staff, such as supervisions and team meetings, had not happened for some time and morale was low, in part due to the lack of effective leadership.

The provider had employed the services of an external consultant to assist with auditing work but we found this to have been ineffective.

Waterloo House Rest Home 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.

The inspection was prompted in part by notification of an incident in which a person using the service had died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk and the accuracy of care planning documentation. This inspection examined those risks.

We visited the service on 20 and 21 June 2018 and the inspection was unannounced. We do this to ensure the provider and staff do not know we are coming. The inspection team consisted of one adult social care inspector and a specialist advisor who had a background in dementia care.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescales. We contacted professionals in local authority commissioning teams, safeguarding teams and Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services.

During the inspection we spent time speaking with seven people who used the service and five relatives. We observed interactions between staff and people who used the service throughout the inspection, including at lunchtime. We spoke with twelve members of staff: the deputy manager, the consultant supporting the

management team, six care staff including the senior carer, one domestic assistant, two cooks and the activities coordinator. We spoke with eight external health and social care professionals during the inspection. We looked at six people's care plans, risk assessments, medicines records, staff training and recruitment documentation, quality assurance systems, meeting minutes and maintenance records. We communicated with the nominated individual via email after the inspection. A nominated individual has overall responsibility for supervising the management of the regulated activity, and ensuring the quality of the services provided.

Requires Improvement

Is the service safe?

Our findings

We reviewed the storage, administration and disposal of medicines and found practices were not always in line with guidance issued by the National Institute for Health and Care Excellence (NICE). For instance, PRN protocols were not in place. These are specific protocols to assist staff in how and when to administer 'when required' medicines. These are considered good practice (NICE, 'Managing Medicines in Care Homes', 2014). One person's insulin was kept in the kitchen fridge as the medicines fridge was broken, meaning there was a heightened risk of cross-contamination, or the medicine being lost.

One person received medicines covertly (this means without their knowledge) but this had not been appropriately risk assessed, nor was a best interest decision evidenced. Staff were unaware of best interests decision-making processes. Anyone receiving covert medicines in a care home setting should have this decision made in their best interests and this should be documented appropriately (NICE, 'Managing Medicines in Care Homes').

We undertook observations of medicines administration and found, whilst the senior carer did not make any errors, they were placed under significant undue pressure by having to regularly interrupt the administration of medicines. For example, to answer the front door as well as ensure people using the service who tried to leave via the front door were appropriately redirected. This meant there was an increased risk of medicines errors happening.

There had been no medicines audits since January 2018 and there was a distinct lack of oversight. For example, the last medicines competence assessment of staff was in 2016, meaning, whilst senior care staff administering medicines did demonstrate a good understanding of people's needs, the provider had not ensured there was a process in place to encourage good practice and identify and reduce poor practice and errors.

We found other instances of lessons not being effectively learned after incidents. For example, there had been concerns raised by the safeguarding team in previous months about how some people who used the service were at risk of leaving the premises via the fire doors. This had not been acted upon by the time of the inspection. Had the provider reviewed this information and looked for trends, they may have identified other areas of concern. For instance, the kitchen door had not been lockable for six weeks, presenting another risk to people who used the service. This was fixed during the inspection.

We found risk assessments and relevant actions to be insufficient. For instance, two people were assessed as being at high risk of pressure sores but did not have the relevant risk management plans in place. Staff knowledge of people's needs and the risk they faced meant people had not suffered because of the poor documentation in place, and that the impact of poor risk assessments was somewhat reduced. The provider, however, had failed to ensure risks were adequately documented and this presented an ongoing risk, for instance if new staff were to support people who used the service.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Service users had a range of health conditions and complex needs and required significant support from staff, who were evidently working extremely hard. All staff we spoke with agreed they felt they could better support people if there were more staff. CQC received a range of extremely positive feedback from a range of stakeholders and families regarding the dedication, diligence and hard work of staff. We found they had ensured people's basic needs were met and people were kept safe, in spite of the lack of adequate governance and support from the provider and registered manager.

People who used the service consistently told us they felt safe, for example stating, "The staff are always there – they can't do enough," and "I have been made to feel at home very quickly. I have no concerns." Relatives likewise told us, "I have never had a concern – the staff are always welcoming and [person] is always looked after." External professionals we spoke with, for instance a GP and a care manager, agreed that staff had successfully ensured people remained safe.

We observed people interacting in ways that demonstrated they were comfortable in the presence of staff. On multiple occasions staff were able to calmly redirect a person who was beginning to feel anxious and ensure they were reassured by either a familiar place or conversation.

There were sufficient domestic and laundry staff but we found that, due to domestic staff finishing at 2pm at the latest, there was additional pressure on care staff to maintain the cleanliness of the premises after this. The registered provider agreed to review domestic staffing hours and deployment. We found the premises to be in need of refurbishment and there were some isolated instances of poor infection control practice, but staff worked hard to maintain standards. The kitchen was in need of a deep clean and the provider agreed this would be done at the end of the week. The cooks did not have sufficient time to prepare people's meals and undertake deep cleans of the kitchen.

We found the majority of servicing and maintenance was in place to ensure equipment was fit for purpose, for example gas safe testing, portable appliance testing (PAT), fire safety equipment servicing and lifting equipment checks.

We reviewed a range of staff recruitment files and found pre-employment checks such as enhanced Disclosure and Barring Service (DBS) checks had taken place. One member of staff had declared a criminal record and this had not been risk assessed. There was no formal risk assessment on their recruitment file, or evidence of agreed control measures in place. This meant the possible risk presented by a prospective member of staff had not been documented or assessed.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood their safeguarding responsibilities and had received safeguarding training. They knew how to contact external agencies should they have concerns about the service.

Requires Improvement

Is the service effective?

Our findings

We reviewed staff training information. We found that staff training in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) was not in place according to these records. When we spoke with staff, they were unable to explain the relevance of the MCA's principles or give examples of how they respected and considered people's capacity on a day to day basis. Some staff could recall having some training in this area but they did not have a current working knowledge in line with good practice. External professionals we spoke with stated they felt staff, including management, needed to have refresher training regarding MCA/DoLS. We also found this to be the case.

The 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).

We observed numerous interactions whereby staff asked people for their consent and gave them choices during day to day interactions, for instance what meal they would like, or what they would like to watch on television. Staff knowledge of when and why people would need to be subject to a DoLS was not consistent and needed to improve at all levels. We found that staff did not have a working knowledge of who was subject to a DoLS and, where these records were in place, we found some applications had expired, meaning people were at risk of having their liberty deprived unnecessarily. In two instances we saw information in the person's assessment prior to moving to Waterloo House which stated they required a DoLS, yet there was no evidence of a capacity assessment taking place or an application to a local authority to deprive the person of their liberty. This meant people who may need their liberty restricting for their own safety had not been properly assessed by the provider to identify, record and act on this need. The provider agreed to review all people's DoLS status as a priority.

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

The service's training matrix was unavailable at the time of inspection, with the deputy having no access to it and the registered provider acknowledging that the interim manager would be 'rebuilding' an up to date training matrix. This meant it was difficult to establish which staff had received appropriate training and who required refresher training.

The provider had failed to put in place appropriate support measures for staff. We found that supervisions and appraisals had not been routinely or consistently conducted with staff. A supervision is a formal meeting between a member of staff and their manager, to discuss training needs, personal development and any concerns. An appraisal is an annual review of staff performance. The supervisions file demonstrated

that the last supervisions held with staff were in February 2018. Staff we spoke with confirmed they had not had formal supervision meetings recently. Night staff we spoke with confirmed they had not had a formal supervision meeting for over a year. This meant staff had not been appropriately supported in their role to ensure they remained competent.

Formal staff meetings had not taken place for over a year, meaning staff did not have a formal means of raising issues or concerns with the registered manager in a group setting, nor were core messages shared with staff on a group basis.

Staffing levels were a concern. There was no dependency tool available to review during the inspection and the deputy manager was unaware of one ever being used. A dependency tool ensures the provision of staff is based on the needs of people who use the service. The provider subsequently shared the tool the new interim manager was planning to use but this still did not factor in the layout of the environment or the high proportion of people who required time-consuming redirection strategies from staff to make them safe and free from anxiety. Furthermore, any dependency tool is dependent on accurate information regarding people's needs; these records were not in place at the time of inspection.

We found multiple examples of there being insufficient staff to safely meet people's needs. This included non-care staff helping people who used the service who were confused, one member of kitchen staff having to prepare 36 meals, including for some people with specialised diets, with no kitchen assistant, and the activities coordinator helping with care tasks rather than being able to focus on planning and delivering activities. Night shift consisted of four staff on shift and those we spoke with confirmed people who used the service would often require two-to-one support during the night. This meant there was no opportunity for night staff to have supervisions or competency assessments, and that the administration of medicines was often rushed. Two people who used the service told us they often had to wait for help during the night. The provider put in place an additional member of staff on nightshifts following the inspection and employed a part time kitchen assistant with a view to finding a permanent member of staff in this role.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found a number of training certificates in the management office which demonstrated staff had received a range of appropriate training other than MCA/DoLS. For example, the majority of staff had received dementia awareness training, health and safety, infection control, moving and handling, safeguarding, fluids and nutrition, medicines, fire safety and equality and diversity. We observed instances of staff using appropriate moving and handling techniques during the inspection.

We spoke with staff about a range of people's healthcare needs and they demonstrated a strong understanding of people's needs. This meant, whilst one area of training was significantly lacking, staff generally had the necessary skills to perform their roles well.

Domestic staff told us they had received no formal dementia awareness training recently. We observed them interacting compassionately and patiently with people who used the service and they evidently had a good understanding of people's needs. Up to date training will enable them to more fully be aware of the potential needs of new people who may use the service.

We recommend that the provider ensures ancillary staff such as domestic, laundry and kitchen staff, receive dementia awareness training, as they regularly interacted with people who used the service.

Whilst the majority of care records would benefit from a wholesale review and there were gaps in some record keeping, we found the documentation of visits and advice by external healthcare professionals to be good. Information was clear, easy to access, and had been acted on by staff.

There had clearly been regular involvement by external nursing and other support, such as the behavioural team. Feedback from these professionals was consistently strong in terms of the information they received from care staff and their opinion of the ability of care staff to meet people's needs.

We found there to be sufficient and appropriate bathing and toileting facilities at the service, with evidence of some recent refurbishment. Other areas of the premises were not currently fit for purpose.

The ground floor had a 'garden room', a large lounge area overlooking a decking area. This had been described as nearly ready for people to use at the last CQC inspection a year ago (May 2017). People who used the service were still not able to access this room. It was used for storage, for instance of new office furniture and cupboards, and for external professionals on their visits. There was new unused garden furniture in this room which staff told us had been there for a year. The patio doors still required work to complete their installation, despite being incomplete at the last CQC inspection. They had work done at the end of day one of the inspection to properly seal the frame with silicone and to put back the UPVC finishing. This meant people only had access to one of the lounges. This lounge was well used but not large enough for all people who used the service, should they choose to sit there. The 'garden room' had the potential to be a pleasant space for service users, with access to a small decked area. This outdoor area was also in a state of disrepair, with overgrown raised beds. Two people we spoke with during the inspection commented on how they used to enjoy gardening. This was a missed opportunity by the provider to ensure there was a safe outdoor space for those people who enjoyed gardening.

At the last inspection we recommended the provider find a different room for the manager's office, which was not fit for purpose, nor fully confidential. At this inspection nothing had changed and the office was chaotic and too hot to work in effectively.

One person's bedroom looked out onto a small yard area which contained a disused section of broken fencing. The deputy manager confirmed this had been there for some time and was an eyesore for the person who used the service.

There was one hoist in operation. People on the ground floor and first floor required hoisting and this had to be transported in the lift, which was old and slow. The lift had broken down twice in the past six months. The hoist itself was operated via a crank handle to adjust it, such that care staff had to exert a considerable degree of energy to correct the height of it before use. Where people may be anxious or upset, this added significant time on to how long it would take staff to transfer a person. The provider confirmed they had ordered a new hoist after the inspection.

The service had only one sling in use at the time of inspection. Whilst it was in working order it meant there would be difficulties in ensuring people could be evacuated safely in the event of an emergency and also that people may have to wait to receive care. The provider confirmed they had ordered a range of new slings after the inspection.

This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had a choice of meals and gave positive feedback about the levels of choice and range of food at the

service. People told us, "We love fish on a Friday," "The meals are always very good," and, "I've eaten all the bacon, I think – I have a fry up every morning with the works." Relatives similarly raised no concerns and spoke positively about how staff helped people maintain an appetite. We observed mealtimes and found them to be somewhat task focussed and rushed, with the cook struggling to ensure all people who used the service received their meal in a timely way. They did so thanks to the support of other staff but, as discussed in the Safe section, they required more formal staff support to ensure people's needs could be better met. We observed refreshments being offered throughout the inspection and, where people had their daily fluids recorded, we saw these did not present risks of dehydration.

Requires Improvement

Is the service caring?

Our findings

We received consistently exceptional feedback from people who used the service, their relatives and external professionals about the commitment of the care staff team, their compassion and desire to 'go the extra mile' in order that people were cared for in a person-centred, dignified way.

People told us, "They're lovely," "I get on with them great and I haven't been here long – they were really nice and welcomed me," and "Nothing's a bother to them". One person gave us a smile and a thumbs up when we asked them if they liked staff and living at the service.

One external healthcare professional told us, "They are so caring. If I needed a service to support a relative living with dementia I would choose this service. It has a lot of issues with being a bit shabby and in need of investment but the staff are just amazing and it feels like a home for the people here." Another said, "I've been coming here for twelve years and it's the best one I go to in terms of the standard of staff care – they are all dedicated to what they do. They keep it going. I'd be happy to recommend the service because of them but it has other things to sort out. It can't keep relying on the goodwill of staff."

There was a strong consensus of opinion from all people we spoke with across a range of contexts that the best thing about the service was the attitude and caring behaviours of care staff. The provider and registered manager had not however ensured the staff team and the people they cared for were adequately supported in terms of staffing levels, training, safety, and governance.

People's individualities were respected by staff. For example, one person had a pet dog who stayed in their room and staff helped them to walk it every day. The person was not able to walk the dog as much as he would like and staff ensured this was done. This further contributed to the person feeling at home, whilst other people who used the service we spoke with enjoyed having the dog around. One person living with dementia had two dolls, which clearly gave them comfort, as they looked after them and spoke with them regularly. Staff were always tactful in their interactions with the person and enabled them to look after these dolls, for example through bringing in spare clothes.

People were treated with dignity and respect and staff were suitably knowledgeable in these areas. We observed numerous interactions between staff and people who used the service that demonstrated this. When we asked people, they said, "Oh yes, I am treated with respect at all times," whilst one relative said, "They're not able to communicate well any more but staff know them so well, they take their time and this puts [person] at ease." Staff communicated well with people who used the service throughout the inspection, tailoring their approach when needed to make sure they could be understood. For instance, quickly acknowledging that a person was talking about a subject linked to their youth in an involved way, and taking an interest in their story.

We found the atmosphere was welcoming and vibrant, although at times chaotic, with the manager's office at the front entrance, alongside seating areas where a number of people who used the service would congregate and sometimes want to leave the service. The provider had not made good use of the 'garden

room' or the outdoor space and there was therefore a high concentration of people in the front of the service, making it feel at times too congested and having the potential to unsettle people who were already feeling anxious.

People who used the service and their relatives confirmed they were consulted regarding how they wanted their care to be delivered. Whilst we found significant gaps in record keeping, relatives were consistent in telling us they were always kept abreast of people's needs and involved in decisions.

Whilst some people's rooms we observed were tired in terms of décor and in need of refurbishment, they were personalised with pictures, memorabilia and their own belongings. People consistently told us they felt at home.

Requires Improvement

Is the service responsive?

Our findings

In our conversations with staff we found some evidence of people's changing needs being identified and met, although documentation was lacking in this regard. There were a number of monthly reviews of care plans which stated, 'no change' when there had in fact been significant changes. For example, one person's mobility care plan referenced their need to have staff support when using their walking frame, but they were now permanently cared for in bed. Another person required the use of the hoist but the relevant care plan merely stated, "Full assistance required." Some people had diet controlled diabetes. Whilst staff knew what the risk factors were and liaised well with external nurses, there were no specific diabetes care plans in place. This is good practice and meant that people's wellbeing was dependent on the existing staff team knowing their needs well, rather than having supportive, accurate care planning in place, should staffing change. The danger was any new member of staff, reliant on these plans, would not be accurately informed about people's needs, leaving people at risk.

The majority of care plans we saw were not person-centred. Person centred means that care is planned and delivered in a way that sees the people as equal partners in planning and puts their needs and individualities first. Care plans contained little information about people's backgrounds, such as their favourite pastimes and interests. This meant, even if the activities coordinator had time to review these in order to plan activities, there was insufficient information to inform person-centred planning. The accuracy of records is discussed further in the Well-Led section. Whilst people's basic care needs were being met we found regular reviews of this information were not meaningful or responsive.

We received a range of positive feedback about how the activities coordinator and other staff proactively engaged and encouraged people to take part in activities, largely in the lounge area. For instance we observed people enjoying an old film during our inspection, as well as an afternoon of dancing. External professionals we spoke with confirmed these types of activities were commonplace at the service and there was, "Always something going on." Relatives told us, "They are great with the residents and are always singing along or getting them to do things."

We found the activities coordinator could be better supported to fulfil their role. For instance, on the first day of the inspection we found the room they had previously used to plan activities was full of clutter and debris. This had been cleared by day two of the inspection and the activities coordinator told us they hoped to use the space to plan activities, store resources, and also for one to one time with people who did not enjoy group activities. Currently the activities coordinator was not given sufficient supernumerary time to plan and deliver activities, or one-to-one time with people. They were assigned 21 hours per week to do this but, as they had a care background and staffing levels were not always adequate, they often assisted with care tasks. The activities coordinator needed to be given adequate supernumerary time to complete this planning and preparation of activities work on a regular basis, as people's needs and interests change.

We recommend the provider consistently uses a recognised life history tool to document people's preferences and interests, and then to review these when planning activities.

We received exceptional feedback from external healthcare professionals about how well staff cared for people at the end of their lives. One told us, "They go above and beyond, certainly. They do everything they can to make sure that person has the choice to be at peace here in their home if that's what they want." Other professionals confirmed staff worked responsively with external nursing support when people were approaching the end of their lives. Relatives we spoke with confirmed they were kept well informed when people's needs changed or when staff may be concerned about a person's deterioration.

With regard to complaints, there had only been one recently and we saw it had been addressed by the registered manager. All people we spoke with and their relatives told us they felt comfortable raising concerns if they had to and understood the complaints process.

Inadequate

Is the service well-led?

Our findings

The registered manager had registered with the Care Quality Commission (the Commission) in December 2014 and had previously worked at the service in a caring role.

We could not talk to the registered manager at the time of inspection as they were unavailable. The deputy manager had a good knowledge of people's care needs and facilitated the inspection but did not have oversight of the management structures or systems in place. We liaised with the provider after the inspection, who provided more documentation regarding the governance of the service.

The provider and registered manager had failed to ensure adequate monitoring and quality assurance systems were in place which had placed service users at risk of harm or abuse, put significant additional strain on the care staff team and ensured no lessons were learned or good practice had been implemented.

During the inspection, we asked to review a range of audits relating to quality assurance and safety monitoring but there was limited information available. The registered manager's audit file set out how often these checks should be undertaken but we found they had not adhered to this plan.

Medicines audits had not been completed since January 2018 and we identified a number of areas of poor practice that effective audits could have identified and reconciled.

Care plan audits had been completed at a rate of five per month until May 2018 although these audits were limited to one line of information and evidently had not picked up on the issues identified at the inspection.

The last falls audit was in November 2017. Meaningful recent audits would have identified people who had suffered a higher number of falls and could have ensured prompt mitigating actions could have been put in place. For instance, one person had suffered a significant number of falls from their standard height bed onto a crash mat but at no point had an adjustable bed that could be set much closer to the floor been suggested as an improvement.

The last infection control audit was in December 2017 and we found some obvious areas of required improvements that should have been identified by any audit or 'walkaround', for instance a loose hand rail in a w/c, loose carpet outside one person's bedroom and a dirty carpet in the main ground floor corridor.

The provider employed a consultancy firm to conduct twice monthly audits of the service which were comprised of a 'Health and Safety' checklist, as well as a conversation with between two and three staff and two and three service users. We found these audits to have been ineffectual with regard to the concerns identified on the inspection. The provider also stated they visited the service approximately every three months but that they did not document this and did not undertake any formal audits.

Overall record keeping was poor across many aspects of the service. For example, care records did not contain completed or robust risk assessments. Some care plans were missing or inaccurate. Food/fluid

charts had not been totalled or analysed. Care staff were not aware of the importance of analysing such information to identify when someone may be more at risk of dehydration and therefore associated risks such as pressures sores.

The environment of the manager's office was not conducive to effective working and had been so for a number of years. There was insufficient space to store care documentation in an orderly fashion. All staff and external professionals we spoke with were aware of the impracticality of this room. The provider had failed to effectively act on a CQC recommendation of the previous year in this regard.

These findings demonstrated a wholesale and prolonged failure to adequately analyse and audit key aspects of the service and people's care needs and the changing risks they faced. The provider had failed to ensure adequate quality assurance processes had a meaningful positive impact on people who lived at Waterloo House.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found morale was low and staff did not receive good levels of leadership and support, despite their ability to continue to meet people's needs in a warm, patient manner under considerable pressure. Staff felt part of a mutually supportive team in terms of their peers. We spoke with external professionals who agreed that the service lacked direction and that this had been the case with the service for as long as their involvement with it. They said, "It's always been a battle for staff to get new equipment – the provider isn't forthcoming," and, "The staff are great but it needs more investment, it always has."

There was no specific service improvement plan in place but a list of ad hoc repairs that had taken place over the past 18 months. The provider and registered manager did not have a coherent strategy for reviewing and improving the service and we found little evidence of the use of best practice.

The culture was one of a dedicated staff team meeting people's immediate needs, sometimes at the expense of documentation, whilst oversight and support of these staff and the service generally was severely lacking. It was to the credit of the care staff team that this culture had so far had little impact on the standard of day to day care people received.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured the Mental Capacity Act 2005 had been adhered to in order to ensure people's capacity and best interests were considered, documented and acted on.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider has not ensured people received safe care and treatment, through poorly managed medicines administration, upkeep of premises and a lack of accurate and up to date risk assessments.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to adequately maintain and update the premises and equipment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure care, systems and processes were subject to adequate oversight and analysis.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to adequately risk assess all prospective members of staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff training was effectively planned and failed to ensure staff knowledge regarding the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards was up to date. The provider had failed to ensure sufficient staffing was in place to deliver care safely and effectively.