Daughters of Mary Mother of Mercy

Waverley Care Home

Inspection report

14-16 Waverley Road
Sefton Park
Liverpool
Merseyside
L17 8UA

Tel: 01517274224

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13 February 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Waverley Care Home is located in a period property near to Sefton Park, Liverpool, and is close to local amenities such as cafes, restaurants, shops and public transport links. There is on street parking and a garden to the rear of the property. The home provides residential and nursing care for up to 20 people, some with diagnoses of dementia or enduring mental health needs. At the time of our inspection 13 people were living there.

This unannounced comprehensive inspection took place on 12 and 13 February 2018.

We last inspected the home in March 2017 and gave it an overall rating of 'requires improvement'. On that inspection we found breaches of regulations 11, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that people may have been deprived of their liberty unlawfully; there were poor recruitment checks, inadequate staffing levels and the premises were not kept safe; there was poor governance at the service to ensure safe and effective care was being delivered and not all staff were suitably trained to meet people's needs.

During this inspection we found that the home remained in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the home's approach to assessing people's mental capacity was poor and was not in line with the principles of the Mental Capacity Act 2005 (MCA) and the associated DoLS. However, we found that the home was no longer in breach of regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as improvements had been made in these areas.

For services rated Requires Improvement on one or more occasions, we will take proportionate action to help encourage prompt improvement. Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires a provider to give us information – when we ask them to do so - about how they plan to improve the quality and safety of services and the experience of people using services. You can see what action we told the provider to take at the back of the full version of the report.

The home had a registered manager. 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.

The home lacked a clear and robust approach to meet the requirements of the MCA and the associated DoLS. The staff we spoke with demonstrated a basic understanding of the principles of the MCA and the associated DoLS and they had recently received training in this area. DoLS applications had been submitted to the local authority for authorisation and there was a system in place to monitor and renew them when needed. However, we saw that several of the mental capacity assessments in people's care files were unsigned, undated, had no plan to review the assessment. These assessments did not involve the people

being assessed, their families, any independent advocates or any relevant health professionals, nor were they supported with best interests decisions. This meant that the home was not acting in line with the principles of the MCA and people living there were not being supported to live their lives in the least restricted ways possible.

The home had introduced a new training system since our last inspection, which included improved records and monitoring of staff training. However, the home did not have a formal and consistent induction process for new staff.

The people we spoke with told us they enjoyed the food and drink at the home. However, we found that not everyone's dietary preferences were catered for.

People living at the home had individual care plans and risk assessments. People's risks were assessed and staff had guidance on how to prevent or mitigate these risks, which we saw was being followed. The care plans we looked at were regularly reviewed. However, the people, their relatives and other relevant health professionals were not formally involved in the process of reviewing this information. Some care plans also lacked personalisation, giving staff only very basic information about the people they were supporting.

We saw that there were policies and procedures in place to guide staff in relation to safeguarding vulnerable adults and whistleblowing. Staff had had training on this and information about how to raise safeguarding concerns was readily available in various places throughout the home. Staff told us that they felt people living at the home were safe, as did the people living there and their relatives.

Medication was correctly administered, stored and recorded.

Staff were safely recruited. Criminal records checks, known as Disclosure and Barring Service (DBS) records, were carried out We also saw that official identification, such as a passport or driving licence, and verified references from most recent employers were also kept in staff files. However, the recruitment files we looked at were disorganised and inconsistent. The registered manager confirmed that they were planning to review and improve these files.

We saw that there was a sufficient number of staff on duty to meet people needs. We also observed caring interactions between staff and the people living at the home.

On our last inspection we found that the registered manager, who is a qualified nurse, did not have adequate administrative support and was regularly completing shifts at the home as a nurse. This meant that the registered manager did not have the time or support to ensure the home was well led. On this inspection we saw that changes had been made in this area, as the registered manager had a full-time administrator and they no longer worked regular shifts as a nurse at the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Policies and procedures were in place to inform staff about safeguarding adults and whistle blowing. Staff were aware of the procedures to follow if abuse was suspected.

Staff were safely recruited and there was a sufficient number of staff on duty to meet people's needs.

Medication was correctly administered, stored and recorded.

The premises were safe, clean and well-maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was not acting in line with the Mental Capacity Act 2005 (MCA) and the associated DoLS.

The home did not have a formal and consistent induction process for new staff.

The people we spoke with told us they enjoyed the food and drink on offer at the service. However, not everyone's dietary preferences were catered for.

Staff were supported with regular supervisions and appraisals and a new training system had been introduced.

Is the service caring?

Good

The service was caring.

People told us the staff were helpful and caring.

Staff had caring and well-established relationships with the people living at the home.

People were assisted and encouraged with their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people's care plans lacked personalisation and the people themselves, their families and any relevant health professionals were not involved in the process of reviewing this information.

People's preferences were recorded in their care plans but they were not always followed.

People were supported to take part in a range of activities and pursue their hobbies and interests.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The home had improved in many areas but significant improvement was still required in others, such as MCA, DoLS and consent.

The home had introduced systems to assess the quality and safety of the service provided.

The home invited feedback about the quality of the service it provided in a variety of ways.

Waverley Care Home

Detailed findings

Background to this inspection

This inspection was planned to check whether the provider was 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 unannounced inspection was carried out on 12 and 13 February 2018 by one adult social care inspector.

We reviewed the information we held about the service before we carried out the visit. This included a Provider Information Return (PIR). The PIR is a document the provider is required to submit to us which provides key information about the service, and tells us what the provider considers the service does well and details any improvements they intend to make.

At the time of our inspection there were 13 people living at the home. During the inspection we looked around the premises and observed the support provided to people in the communal areas of the home. We spoke with seven people who lived at the home, three of people's relatives and friends, six members of staff who held different roles within the home and one health professional visiting people living at the home during our inspection. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at a range of documentation including four people's care records, medication records, five staff recruitment files, staff training records, accident and incident report forms, health and safety records, complaints records, audits, policies and procedures and records relating to the quality checks undertaken by staff and other management records.

We also contacted the local authority for feedback about the home. They told us that at their visit in July 2017 they identified training issues around MCA 2005, DoLS and consent, a lack of continuity regarding planned supervision dates and non- compliance with local authority procedures in respect of reporting incidents.

Good

Is the service safe?

Our findings

All of the people we spoke with, including their relatives and friends, told us the home was safe. They said, "I feel very safe here, the staff are there for me" and "Oh yes, it's very safe, warm and cosy."

On our last inspection we found that the service was not safe because of poor recruitment checks, inadequate staffing levels, the lack of robust and regular risk assessments and inadequate checks of the premises' safety. As a result the home was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On this inspection we found that the home had addressed these areas of concern and was no longer in breach of this regulation.

We saw that there were policies and procedures in place to guide staff in relation to safeguarding vulnerable adults and whistleblowing. Staff had had training on this and information about how to raise safeguarding concerns was readily available in various places throughout the home. Staff told us that they felt people living at the home were safe, as did the people living there and their relatives.

We looked at four care files and saw that risks in relation to people's needs and safety had been properly assessed with risk management plans in place to mitigate any risks identified. These included risks in relation to falls, nutrition, medication and pressure care were all assessed and staff had guidance to follow to prevent or minimise any potential risk of avoidable harm. For example, one person was at risk of falling when transferring between a chair and a wheelchair. Their care plan advised that two carers should assist this person when transferring and they should use a particular mobility aid. We observed that staff were following this advice.

During our inspection we looked around the home and found that it was clean and well-maintained throughout. We looked at a variety of safety certificates that demonstrated that utilities and services, such as gas and electric had been tested and maintained. We saw legionella checks had been appropriately carried out. Legionella is a water-borne bacteria often found in poorly maintained water systems.

A fire risk assessment of the premises had been carried out and this was regularly reviewed. We saw that fire safety and firefighting equipment at the home had been regularly checked and maintained. We also noted that the home had invested in a new fire alarm system and emergency lighting since our last inspection. Staff had received fire safety awareness training. There were Personal Emergency Evacuation Plans (PEEPs) for each person giving clear information about what assistance they would need to evacuate in an emergency. These were easily accessible so could be referred to quickly in the event of an emergency and were regularly reviewed and updated by the registered manager. Risk of injury in the event of fire was also reduced as the home carried out regular fire drills. This meant that the people living at the home and the staff knew what to do in an emergency.

We saw during our inspection and in the staff rota records that there was a sufficient number of staff working to meet people's needs and promptly provide them with assistance when they needed it. For example, we saw that there was enough staff to assist and encourage people who needed it at mealtimes. We also saw

that staff were available to promptly assist someone who wanted to go to bed early after their evening meal.

We saw that accident and incident policies and procedures were in place and there was an effective system to record any accidents and incidents that had occurred. Appropriate action had been taken in response to those incidents that had occurred. For example, one person had had a fall. Staff identified that old footwear was the most likely cause and provided them with new footwear to reduce the risk of them falling again.

Staff were safely recruited. Criminal records checks, known as Disclosure and Barring Service (DBS) records, were carried out. We also saw that official identification, such as a passport or driving licence, and verified references from most recent employers were also kept in staff files. The registered manager confirmed that they were planning to review and improve the structure of these files.

Medication was correctly administered, stored and recorded. We looked at three people's medication administration records (MARs) and medication stocks and found that the MARs had been appropriately completed medication stocks were accurately accounted for. The staff we spoke with told us that they were confident managing people's medication and people received the right medication at the right times. We saw that relevant staff had received training on medication administration and there were policies and procedures in place to support staff.

During our inspection we observed that all areas of the premises were clean and tidy. We observed that staff used personal protective equipment (PPE) when necessary, such as when serving people food. We also noted that the infection prevention and control team from the local NHS trust had carried out an audit at the home in November 2017. The home scored 95%, which exceeded the 90% compliance mark.

Requires Improvement

Is the service effective?

Our findings

We asked the people living at the home, their relatives and friends if they thought staff had the skills and knowledge to do their jobs well. They told us, "Yes the staff know what they are doing" and "The staff know how to help, I've never had any problems."

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).

On our last inspection we found that the service was not effective because the home had not followed the MCA and DoLS. Mental capacity assessments had not been carried out properly and nor had best interests meetings been held to assist in this process. As a result the home was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On this inspection we found that the home lacked a clear and robust approach to meet the requirements of the MCA and the associated DoLS. The staff we spoke with demonstrated a basic understanding of the principles of the MCA and the associated DoLS and they had recently received training in this area. DoLS applications had been submitted to the local authority for authorisation and there was a system in place to monitor and renew them when needed. However, we saw that several of the mental capacity assessments in people's care files were unsigned, undated, had no plan to review the assessment. These assessments did not involve the people being assessed, their families, any independent advocates or any relevant health professionals, nor were they supported with best interests decisions. This meant that the home was not acting in line with the principles of the MCA and people living there were not being supported to live their lives in the least restricted ways possible.

We also saw that there was a lack of evidence to demonstrate that the home had obtained people's consent to the care they were receiving. For example, we did not see any documentation to confirm that people's care plans had been discussed with them and that they had provided their consent to the care as planned.

As a result, the home remained in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager acknowledged that the home was falling short of the expected standard in this area and explained that they were committed to urgently addressing this problem. The registered manager also explained that they, along with some other senior staff, were scheduled to attend training on this subject soon after our inspection.

The home had introduced a new training system since our last inspection, which included improved records and monitoring of staff training. This involved an experienced member of the staff team leading the training

at the service with the use of professional resources. At the time of our inspection this was a work-in-progress and the registered manager told us that they planned to have the new system fully embedded by August 2018. The registered manager also explained that they planned to give the member of staff leading the training regular protected time away from their regular duties in order to properly monitor and maintain training at the home. Records showed that staff had completed a variety of training. These topics included safeguarding, first aid, dementia awareness, health and safety, fire safety, pressure sore prevention and awareness, moving and handling.

However, the home did not have a formal and consistent induction process for new staff. It is also recommended that, as part of a robust induction process, staff who are new to care should complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It gives staff who are new to care the introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. This was not considered as part of the induction process at the home. The registered manager was able to give a general overview of how new staff were introduced to working at the home and the people living there, including a health and safety checklist. We were also reassured that records showed the most recently recruited member of staff had completed the majority of the training modules provided. But there was a lack of clarity and supporting documentation around what each new member of staff must do before commencing work properly, such as training and shadowing. This meant people living at the home were at risk of receiving support from new staff that did not have all the knowledge and skills to meet their needs safely and effectively.
Regular supervisions and annual appraisals had been carried out with staff. This provided staff and the registered manager with a formal opportunity to discuss performance, any concerns and to address any training needs.

The people we spoke with told us they enjoyed the food and drink at the home. We saw that meals were freshly prepared each day and people were given a choice of suitable nutritious foods to help them to maintain a healthy and balanced diet. Relevant information regarding anyone who required special diets, such as diabetic or fortified, was stored in the kitchen for guidance.

However, we found that not everyone's dietary preferences were catered for. For example, one person living at the home preferred a particular style of food and this was clearly set out in their care plan. Whilst staff assisted this person to visit a restaurant once-a-month, their preferred food did not feature in the regular menu at the home. We discussed this shortcoming with the registered manager who agreed to make immediate changes to start meeting this person's dietary preference.

Some of the people living at the home were living with dementia. Whilst we saw that the environment was homely and people looked happy and relaxed, there was a lack of dementia friendly adaptations that had been made to the environment. For example, easy-read noticeboards or clocks to help people know the time and date and clearly visible signage to help people navigate their way around the home. These adaptations help to make people's lives easier, safer and more comfortable.

The care records we looked at showed that staff at the home ensured that people living there saw various health professionals regularly or as soon as was needed. This ensured that people's health and wellbeing was maintained. One health professional we spoke with said, "The staff here are great, all of the information and advice we give them is followed and they call us if they need any further advice."

Good

Is the service caring?

Our findings

People living at the home told us, "The staff are lovely, very caring and friendly" and "Oh I'm very happy, it's a lovely home this and the staff are great".

All of the staff we spoke with had worked at the home for over a year or longer. We saw that staff and the people living at the home had caring and well-established relationships. For example, we observed numerous friendly and cheerful interactions throughout our inspection. Staff were also able to tell us about one person's family member who had recently been on holiday. Staff easily explained the details about this and that the person living at the home was looking forward to speaking with them. This demonstrated that staff were caring and interested in the things that were important to the people living at the home.

The relatives, friends and visiting health professional all told us that staff at the home were warm, friendly and welcoming. We also observed this on our inspection.

We saw that people's dignity and privacy was respected. All of the people living at the home were clean and well-dressed. We saw that a hairdresser visited people at the home regularly. One person was very happy and proud to show us their hair after they had had it done. Staff communicated with people discretely when they were assisting people from communal areas for personal care. Staff were also able to give examples of how they protected and maintained people's dignity and privacy. These included ensuring people's curtains were closed when they were dressing and always knocking on people's doors before entering. We also saw that people who preferred to spend time alone were supported to do so.

People's religious and spiritual needs were supported. For example, a priest regularly visited the home to hold Holy Communion for those who wished to take part. The registered manager told us that people were able to choose whether or not to participate and staff respected people's differences, treating everyone equally and fairly.

We saw that confidential information was stored securely. This included people's care plans and care notes. The registered manager explained that they had recently purchased some additional storage which will assist with the archiving of old records.

We saw that people had been supported to personalise their own rooms. The people we spoke with told us they were happy with their rooms. One person said, "I've lived here for many years, I'm quite happy and comfortable with my room." We saw that people had family photos and other personal items in their rooms to make them feel homely.

We saw that staff assisted and encouraged people with their independence. For example, one member of staff regularly assisted people to the local shops, bank and post office. We noted that staff were flexible and responsive to people's requests to make these trips out into the community.

Requires Improvement

Is the service responsive?

Our findings

The people we spoke with and their relatives and friends told us that the staff supported people as and when they needed support and in the ways they needed it. One person said, "I am very happy with [Relative's] care, they are very settled living there and the staff are there for them."

Initial assessments were completed prior to people moving into the home. This enabled the registered manager to look at people's needs and determine whether the service was able to meet their needs.

People living at the home had individual care plans and risk assessments. People's risks were assessed and staff had guidance on how to prevent or mitigate these risks, which we saw was being followed.

The care plans and risk assessments we looked at were regularly reviewed by staff. However, people, their relatives and other relevant health professionals had not been involved in the process of reviewing this information. This meant that there was a risk this information was not entirely accurate or person-centred.

The care plans did not have a clear and consistent structure, which meant that it may take staff longer than necessary to find information they needed at a particular time. Some of the care plans we looked at also lacked personalisation, giving staff only very basic information about the people they were supporting. For example, one person's 'This is me' document contained brief information about their support needs but little detail about them as a person. This meant that the home's care plans were not person-centred.

We also found that some information and guidance set out in people's care plans was not being followed. For example, one person living at the home preferred a particular style of food and this was clearly set out in their care plan. However, their preferred food did not feature in the regular menu at the home. We discussed this shortcoming with the registered manager who agreed to make immediate changes to start meeting this person's dietary preference.

The registered manager explained that they planned to review and transfer everyone's care plans onto improved paperwork in Spring 2018.

We saw that the home assisted people to pursue their hobbies and interests. For example, one person told us that they had a keen interest in films and said that watching films was how they liked to spend their time. We saw that this person had a DVD player and a vast collection of DVDs in their room. The registered manager also explained that one of the people living at the home told them that they enjoyed photography but had not done this for many years. The registered manager told us that they had provided the person with a camera so they could enjoy this hobby once again.

There was a range of activities on offer at the home provided by two activities coordinators who worked five days-a-week. These activities included armchair exercises, various games, reminiscence, discussions about current affairs and group trips out. The activities coordinators often took people living at the home out to appointments or to other activities, such as going to the shops, the bank or the post office. We saw that

some of the people living at the home regularly attended a lunch club at a local community centre. We saw that when the group returned they were very cheerful and happy. They enjoyed telling us that they had had a nice time out and had enjoyed their lunch.

People were supported to make choices about how they spent their time. For example, we saw that if people wanted to spend time in their room on their own or they wished to go to bed early after their evening meal then staff supported them to do so.

We saw that people who needed to wear glasses or hearing aids were doing so. This enabled them to go about their daily routines, such as reading the paper or watching television, as normal.

There had not been any formal complaints since our last inspection. The home had a complaints policy and process in place. We saw that people and their relatives were encouraged to make a complaint if they needed to and the details of how to do so were easily accessible. People told us that they had never had any reason to make a complaint but they felt comfortable speaking with the staff if needed.

None of the people living at the home required end of life care. However, the registered manager explained that the necessary training and processes would be put in place, along with liaison with the relevant health professionals, to address this if anybody needed it.

Requires Improvement

Is the service well-led?

Our findings

The registered manager and the staff team had worked hard to address the issues highlighted by our last inspection and they had improved in many areas. The home was no longer in breach of regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the home was safe, a new staff training system had been implemented and improvements had been made to the governance and quality assurance of the home.

However, as we have explained in this report, there remain several areas in which the home still needs to improve. In particular, the home remained in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the home's approach to assessing people's mental capacity was poor and was not in line with the principles of the Mental Capacity Act 2005 (MCA) and the associated DoLS.

The registered manager was open and transparent with us during this inspection and they recognised that there were still a number of areas in which they needed to improve.

The registered manager acknowledged that they were not currently a member of any local partnerships or groups. These organisations help to gather managers and providers to share learning and ideas about best practice with other health and social care providers. The registered manager explained that this was something they were now considering.

On our last inspection we found that the registered manager, who is a qualified nurse, did not have adequate administrative support. They were also unable to properly meet the requirements of the registered manager's role, as they were regularly completing shifts at the home as a nurse. On this inspection we saw that the registered manager now had appropriate administrative support in place. The registered manager was only completing nursing shifts once-a-month in order to manage and monitor the monthly changeover of medication or as a last resort to cover staff absence. This meant that the registered manager now had the time to focus on the important aspects of this role, such as quality assurance and good governance.

The people we spoke with said the registered manager was friendly and approachable and we also saw this during our inspection. The staff we spoke with said that they felt well-supported by the registered manager and that there is positive culture amongst the staff. One member of staff said, "We work hard together as a team to give people the best possible care."

We saw that a range of audits had been introduced since our last inspection to assess the quality and safety of the service provided. For example, health and safety and fire safety checks. These records were well-maintained, up-to-date and readily available. This meant that the safety and quality of the service was now regularly monitored, assessed and ensured.

The home had policies and procedures in place that staff were able to access if they needed any guidance.

We saw that these policies and procedures were up-to-date and regularly reviewed.

Records showed that the registered manager had held regular staff meetings since our last inspection. These meetings were documented and provided staff with the opportunity to receive and share any important information.

The two activities coordinators held regular meetings with the people living at the home. These meetings were well-attended and gave people the opportunity to provide their comments and feedback about the home. We saw that these meetings were documented and gathered feedback about any recent significant events, such as Christmas, along with more day-to-day feedback about people's rooms, the quality of the food and things people would like to do. Staff at the home also encouraged visitors to leave their feedback about the home. We saw that visitor questionnaires were readily available by the signing-in book.

Registered providers are required to inform the CQC of certain incidents and events that happen within the home. The home had notified the CQC of all significant events which had occurred in line with their legal obligations. The home was also meeting its legal obligation to clearly display its most recent CQC rating at the home.

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 home lacked a clear and robust approach to meet the requirements of the MCA and the associated DoLS. There was also a lack of evidence to demonstrate that the home had obtained people's consent to the care they were receiving.