Vivacare Limited

Waterloo House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.
The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

This inspection took place on 12 and 25 October and 1 November 2016 and was unannounced. Day one of the inspection was undertaken by one adult social care inspector. Days two and three of the inspection were undertaken by one adult social care inspector and one specialist advisor, who had a background in nursing. The inspection was undertaken following the Care Quality Commission receiving information of concern from the local safeguarding authority and externally employed professionals visiting the service.

Waterloo House is a care home which provides accommodation and personal care for up to 20 people who have mental health needs. At the time of the inspection there were 19 people living at the service.

At the time of the inspection there was no registered manager in post. 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. A new manager had been appointed who was due to commence their role in December 2016.

Following the inspection, CQC made safeguarding alerts in respect of both the whole service, and in relation to four individual people who lived at Waterloo House.

People who used the service were not always protected from the risks of abuse. There were some instances, where people who were at risk of harm, were not reported to safeguarding authorities, or satisfactory plans were not put in place to minimise the risk of harm to others. The details kept by the service of who to contact to discuss safeguarding concerns were seen to be out of date.

People were not kept safe within the environment because infection control practices were not sufficient. There was a lack of Personal Protective Equipment (PPE) within the home, to prevent the cross infection of transmittable diseases. Where people had illnesses which may have posed a risk of cross infection to others, their care plans were out of date and lacked guidance for staff on managing the risk. We observed unsafe practices around infection control in relation to items in bathrooms, such as bath towels. Routines intended keep the home clean and protect people from the risk of cross infection were not always satisfactory. For example the communal drinks station was seen to be dirty with used cups put back in the clean area by people throughout the inspection.

People were not always safe within the environment. We found a number of environmental hazards such as an extremely hot radiator in one of the bathrooms without a protector and obvious ligatures such as long call bell cords and ligature points such as metal hooks in shared bathrooms. We found the maintenance room containing dangerous items such as screwdrivers, machinery and knives to be unlocked and unsupervised. We found that people had PEEPS (personal emergency evacuation plans) in place however they had not been recently reviewed. In addition, they were stored in the back of people's individual care records and may not have been accessible in a timely manner in the event of an emergency.

Accident and incident forms had been completed in respect or significant events such as when police involvement had been required or when a person had taken too much medicine. These forms lacked important detail such as the date or the outcome of the incident. This would be important in terms of identifying themes and in reducing the likelihood of a reoccurrence. Where incidents had occurred, risk assessments and care plans were not updated in response.

People's liberty and freedom of movement were not always protected. We found no evidence that people's capacity to make decisions had been assessed in line with the Mental Capacity Act (MCA), despite some people being subject to authorisations under the Deprivation of Liberty Safeguards (DoLS). We saw no evidence that best interest processes had been followed to ensure people's care was provided in the least restrictive manner available. We found out of date consent forms which referred to outdated CQC regulations. Where people were subject to other orders, such as the sections of the Mental Health Act (MHA), staff were not always aware of the conditions or restrictions associated with the orders. There was no guidance in people's care records to inform staff of what this meant for the people they cared for.

There was a lack of activity on offer for people who lived in the home. This meant many people had little to do apart from watch television. We were told that there was a mini-bus and people went out on trips on an ad-hoc basis, but there were no personalised plans around this in people's records and no schedule to inform people of planned events.

Care plans did not contain accurate and up to date information, and had not been regularly reviewed. Care plans did not provide suitable guidance to inform staff where people had complex needs which may have put them and others at risk. There were two sets of care records which ran concurrently meaning that some information was duplicated, disorganised and confusing. Some records contained contradictory information. People's confidential information was not always securely stored.

People had access to healthcare professionals but where they had provided advice, this had not always been followed up by staff. We found little evidence in people's records to inform us of when people had been reviewed by their GP or had important checks, for example relating to their diabetes or catheter care. The approach from staff to diabetes care and skin management were inconsistent.

There was no registered manager in post. The previous registered manager had left and a new manager had

been appointed to commence their role in December 2016. Managerial arrangements for the intervening period were not sufficient to undertake the corrective action that was required to ensure the safety of those living at Waterloo House.

Suitable quality assurance systems were not in place to check the service was operating effectively and to drive improvement where it was required. There were no staff or residents' meetings which meant staff and people may not have had the opportunity to offer suggestions on the running of the service.

The service had not always informed the Care Quality Commission of important events and incidents in line with their legal obligations which meant there was a risk of a lack of oversight and potential safeguarding of people using the service.

Some aspects of people's medicines management were not safe. Although people were generally given their medicines as prescribed and on time, where people managed their own medicines the oversight by staff was not always sufficient. Some people were prescribed medicines which required strict controls. Staff were unable to tell us why one person was receiving this medicine. The keys to the drugs trolley and cupboard were not always securely stored. The medicines fridge was situated above a radiator on a window ledge which may have caused problems in maintaining its temperature at the required level although the fridge was in range when we visited.

Staff told us they pressurised and drained, particularly due to some new people who had recently come to live at the service. During our inspection, there appeared to be enough staff on duty. Staff were able to respond to people in a timely manner and appeared unhurried in their interactions. Staff had not received specialised or role specific training in mental health or substance misuse, despite providing support for people who had complex needs and may require a skilled approach to manage their needs effectively.

People told us staff was caring and most staff we spoke with had a compassionate and caring attitude towards the people they supported. We observed some staff interacting in a positive way and using appropriate humour with people using the service. However, we witnessed some incidents which were not professional and respectful.

Staff told us they had undergone an induction and that they received supervision and an appraisal. Staff had received mandatory training and some role specific training in areas such as managing aggression. Some of this required updating, however this was being actively addressed during the inspection. Staff were committed to learning and improving their knowledge base.

People's monies were stored securely, and suitable records were kept of expenditure made on their behalf.

People told us they enjoyed the food. We observed the lunchtime experience and saw that people appeared comfortable and content. The food looked plentiful and appetising and there were alternatives on offer. Where people had particular dietary requirements they were documented in the kitchen so that staff were aware.

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?

Inadequate

The service was not safe.

People were at risk of becoming unwell or acquiring illnesses because infection control practices were not sufficient.

People were not kept safe within the environment because hazardous items were not securely stored.

People's risk assessments did not contain sufficient guidance for staff on managing the risks associated with their complex needs.

People were not always protected from the risks of abuse. People who were at risk of harm were not always reported to safeguarding authorities, or satisfactory plans were not put in place to minimise the risk of harm to others.

Is the service effective?

Inadequate

The service was not effective.

People's liberty and freedom were not protected because their capacity to make certain decisions were not being assessed and best interest processes were not being followed in line with the principles of the Mental Capacity Act (MCA).

People were cared for by staff who had only received basic training on mental health which was insufficient to meet their complex needs.

People's health care needs were not adequately met. Guidance from health care professionals was not always followed.

People's health care needs were not assessed or monitored appropriately. Screening tools were not used and charts were not always completed as required.

People enjoyed the food. It was of sufficient quality and quantity and there were alternatives on offer.

Is the service caring?

Requires Improvement

Aspects of the service were not always caring.

People were not always treated positively or respectfully by staff supporting them.

Confidential information was not always securely stored.

Staff did not know some of the people living at the service well and therefore were not always able to meet their needs in a way that suited their preferences.

Is the service responsive?

Inadequate

The service was not responsive

People did not have care plans, which were kept up to date and reflected their needs, preferences and risks.

Care plans were not personalised and often contained minimal information around people's background, history, likes and dislikes.

People were not always kept socially, cognitively and physically engaged due to a lack of personalised activity on offer within the service.

There was a complaints policy which was situated in a prominent place within the service, alongside guidance on how to make a complaint.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager in post. The new manager was not due to start for several weeks and there were issues around the sustainability of managerial cover until that time.

There was a lack of opportunity for staff and people to offer suggestions on the running of the service as there were no staff or residents' meetings.

The quality of the service people received was not effectively monitored as the service did not have systems and processes in place to assess this.

Waterloo House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12, 25 October and 1 November 2016 and was unannounced.

Day one of the inspection was undertaken by one adult social care inspector. Days two and three were undertaken by one adult social care inspector and one specialist advisor with a background in nursing. Prior to the inspection we reviewed information we held about the service. This included notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection, we looked around the premises and observed the lunchtime experience. We spoke with eight people who used the service. We also spoke with six members of staff. Following the inspection, we spoke with four professionals who had been in contact with Waterloo House.

We looked at eight records relating to people's care, personnel files and training certificates. We observed medicines being administered, reviewed care records associated with medicines management and looked at the arrangements for the storage and disposal of medicines. We also reviewed a range of policies and procedures.

Inadequate

Is the service safe?

Our findings

The service was not safe. Following the inspection, CQC made safeguarding alerts in respect of both the whole service, and in relation to four individual people who lived at Waterloo House.

People were not kept safe within the environment because infection control practices were not sufficient. There was a lack of PPE within the home, to prevent the cross infection of transmittable diseases. On day two of the inspection, we noted a lack of hand sanitising gel or aprons throughout the service, although there were disposable gloves in the bathrooms. No hand hygiene was observed either before or after staff administered medicines. There were no disinfecting wipes or equipment on the medicines trolley to enable staff to sanitise the area before administration. The lack of antibacterial gel was highlighted to staff on day two of the inspection and by day three, we noted three bottles of antibacterial gel had been placed in key areas on the ground floor. We did not observe any additional gels on the second or third floors of the service.

Where people had illnesses which may have posed a risk of cross infection to others, their care plans were out of date and lacked guidance for staff on managing the risk. This meant that staff, visitors and other people living at the service were not adequately protected against the risk of contracting the illness. One person had an open wound which they were seen to touch and scratch before coming into contact with other people's belongings. We were unable to find care plans, risk assessments or precautions in place to manage the risks associated with the open wound or infection control for this person. These concerns were highlighted to staff on day two of the inspection. By day three the person had been seen by their doctor and dressings had been obtained for the wound. The dressing was seen to be in place for most of the third day of our inspection. We observed that it had been removed at times during the day, this was highlighted to staff who replaced it.

We observed unsafe practices around infection control in relation to items in bathrooms. We observed bath towels left in the shared bathrooms. This posed a risk of cross infection. This was highlighted to staff, however when we returned to the service they were still in place. Routines intended to keep the home clean and protect people from the risk of cross infection were not always satisfactory. For example the communal drinks station was seen to be dirty with used cups being put back in the clean area by people throughout the inspection despite some people having illnesses which others were at risk of contracting through this action.

The service was not assessing the risk of, or preventing, detecting and controlling the spread of infections. This is a breach of the Health and Social Care Act 2008 (Regulated Activities). Regulation12(2)(h) Safe Care and treatment

We found safety concerns within the environment. We found obvious ligatures such as excessively long call bell cords in the shared bathrooms. We also found ligature points such as metal hooks on the backs of bathroom doors. One radiator in a shared bathroom was extremely hot without a protector to safeguard people using the bathroom. On day two of the inspection we noted the maintenance room was unattended, and the door was open. Inside, we observed numerous potentially dangerous pieces of equipment such as

screwdrivers and pieces of machinery. These could have potentially been used as weapons, or as a means to self-harm. This was a concern given the needs of the people living at the service. This was highlighted to staff who assured us the room would be locked at all times. On day three, we found this room to be unlocked and unattended again. This time, a sharp knife was noted on the work top in the room, alongside other dangerous items. In addition, we noted that the cutlery was stored in an unlocked cupboard in the dining room, so that knives were accessible to people.

The service was not using the appropriate level of security needed in relation to the premises and equipment. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 15 (1)(b) Premises and equipment.

People who used the service were not always protected from the risks of abuse. There were some instances, where people who were at risk of harm, were not reported to safeguarding authorities, or satisfactory plans were not put in place to minimise the risk of harm to others. For example, we were told that one person had a tendency to seek to obtain money from other people living at the service in order to purchase alcohol. One staff member said; "They use and financially abuse each other. [Person's name] manipulates others for money". This was potentially financial abuse. No action had been taken to inform the safeguarding authority about this situation and therefore the risk of exploitation continued. The details kept by the service of who to contact to discuss safeguarding concerns were seen to be out of date on day one of the inspection.

Staff had not always reported signs of abuse. This was a breach of Health and Social Care Act 2008 (Regulated Activities). Regulations 2014. Regulation 13: Safeguarding service users from abuse and improper treatment.

People told us they generally had their medicines as prescribed and on time. However, we did observe some concerns relating to medicines management. We found that storage arrangements were not always secure. Access to the medicines cupboard and trolley was limited to staff and both were locked with a key. There was a key log which was kept up to date and evidenced handover of the keys between staff. We noted that these keys were kept stored in the kitchen and easily accessible. This included keys to the cupboard containing medicines which required stricter controls. This was highlighted to staff and in response, processes were changed so that the keys remained with the most senior member of staff.

The medicines cupboard was appropriately stocked, however there was no temperature checking and therefore no recording of temperatures within the cupboard. There was a medicines fridge, with daily recording of temperatures, which fell within the correct range. However, we noted that it was stored on a window ledge, above a radiator which may have caused issues with the regulation of its temperature. In addition, we found five boxes of eye drops in the fridge, all of which were opened with no date, meaning it was not possible to know which box was to be used and whether the medicines were due to expire. The medicines trolley appeared well organised, but did not contain wipes in order to support infection control practices.

There was insufficient emergency equipment available at the service, in the event that resuscitation was required. For example there were no emergency grab bags. There were two first aid boxes, however one had been used and not re-stocked. The second box was complete, however we found that the lid did not close and the box itself was visibly dirty with dust on top. There was no evidence of these boxes being audited.

People were protected by suitable staffing levels. People told us they felt there were enough staff on duty to keep them safe. One staff member said; "There are enough staff. We help each other out and we don't tend to use bank or agency staff". Throughout the inspection there appeared to be enough staff on duty to

respond to people in a timely way. Staff did raise concerns to us about feeling drained and exhausted, but confirmed that this was due to meeting the particular demands of some people who had recently been admitted to the service with complex needs.

Accident and incident forms had been completed as required for significant events such as when police involvement had been necessary or when a person had taken too much medicine. These forms were completed by staff and stored within people's care records. The location of the forms in people's records meant there was no oversight by staff to monitor the frequency of their occurrence. The forms we reviewed lacked important detail such as the date the incident occurred, or what the outcome of the incident had been. This would be important in terms of identifying themes and reducing the likelihood of a reoccurrence. Where incidents had occurred, risk assessments and care plans were not updated in response meaning there was a lack of guidance for staff on how to reduce risks.

People had PEEPS (personal emergency evacuation plans) in place, however these had not been recently reviewed. In addition, they were stored in their care records, which were either stored in the office or in filing cabinets in the lounge. This may have been an issue should a swift evacuation be required, as they may not have been accessible or easy to locate in a timely manner. This was being addressed by day two of the inspection and a new file was being put together, to be stored in the reception area.

Recruitment checks were in place. Staff had completed an application form. There were references from someone who had known the person prior to them working at the service. There was a Disclosure and Barring Service (DBS) check in staff files we reviewed. One staff member said; "All checks were completed before I started".

Inadequate

Is the service effective?

Our findings

Aspects of the service were not effective.

People's capacity to consent to their care was not appropriately assessed or monitored. 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 people lack mental capacity to take particular decisions, any decisions 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. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found no records of capacity assessments in relation to any of the care records we reviewed despite a number of the people lacking capacity to make certain decisions. These included records associated with people who had deprivation of liberty safeguards authorisations in place. As people's capacity to undertake decisions was not assessed or recorded it was impossible to determine whether any decisions made on people's behalf were the least restrictive available to them. Applications had been submitted to the supervisory body for DoLS authorisations in respect of two people. However as their capacity had not been assessed, the process had not been followed within the principles of the MCA, which guides decision makers to begin by assuming a person has capacity. The service's approach to working within the principles of the Mental Capacity Act was being reviewed and staff from another home were working towards bringing practices in line with that service. This would involve re-writing care plans, undertaking mental capacity assessments and recording best interest decisions as required.

Some people were subject to other legal authorisations which restricted their liberty and freedom, in the interest of their own, or other people's safety. For example, sections of the Mental Health Act (MHA). Staff we spoke with did not know what this meant for the people concerned and whether there were any conditions attached to the orders which the person needed to comply with. This could have placed the person or others at risk of harm. We could not find documentation relating to these orders. We highlighted this to staff who said that they would seek guidance from the external health care professionals who supported these people and ensure that staff were made aware of any action they needed to take.

We found forms in people's records which indicated that they had consented to elements of their care plans. For example, one person had given staff consent to open their mail. These consent forms had not been recently reviewed and also, referred to out of date CQC regulations. One person's care record contained consent forms which indicated that they had consented to staff undertaking a number of actions on their behalf. These forms had not been reviewed, despite the person having a degenerative condition and having declined cognitively since they were completed.

People's capacity was not assessed and best interest processes were not followed in line with the principles of the Mental Capacity Act. This was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 11: Need for consent.

We asked to review information relating to staff training. We were told that there was no system for logging training centrally and no system to remind staff when it was due to be renewed or refreshed. We were told that the only way to know which training staff had undertaken was to review their certification, which was stored in the back of their personnel file. We reviewed some staff files and observed that they had undergone training identified by the provider as being mandatory, as well as some role specific training, such as managing aggression. Staff files we reviewed indicated that most of the training was due to be renewed having last been refreshed in 2015. Staff told us that their system for accessing training was being reviewed and a new programme of e-learning was being introduced for all staff to work their way through. Staff confirmed that they had only received basic mental health awareness training, despite working with people with complex mental illnesses. For example, staff had not received training around personality disorders. When asked what this meant, one staff member said they thought it referred to "having a split personality". In addition, staff had not received training around alcohol dependency or substance misuse, despite having people who had alcohol dependency issues at the service. This meant that people's needs may not have been supported safely or in line with best practice.

Some staff had not received adequate training around mental health or alcohol dependency despite being in situations where it may be required. This was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12 (2)(C) Safe care and treatment.

People's health care needs were not appropriately managed at the service. Records lacked up to date information around people's health needs and any associated risks. We found letters in people's care records which indicated that they attended reviews with their consultant psychiatrist but this was often not recorded within their files. There was limited evidence of referrals to other professionals or appropriate recording of their treatment and advice.

One person's care plan stated that they needed to have a bowel chart in place in order to closely monitor their bowel movements. In the event that the person had had not opened their bowels in two days the care plan indicated that staff should immediately inform district nurses so they could carry out an emergency procedure. We checked with staff, who confirmed that they were not keeping bowel charts in respect of this person. We were therefore unclear as to how this person's health care was being managed. CQC made a safeguarding alert following the inspection in relation to this concern.

The systems to support people with specific skin conditions were unstructured and inconsistent. We saw body maps where marks or injuries were recorded from either accidents or self-harming. However, there was no treatment plan attached and this had not been linked to the person's care plan or risk assessment. We found no evidence of monitoring, treatment or reporting of these incidents where applicable. This meant that it was not possible to determine if people had received suitable care and treatment for their condition.

People with diabetes did not have their condition appropriately monitored. We found there were inconsistent systems to monitor the blood sugars of people with both type (I) and type (II) diabetes. Nor was there a uniform diabetes management system in place to monitor dietary requirements and weight control or to record checks and management of the condition by the person's GP.

People were not supported to safely manage their needs in relation to diabetes. We were told that one person managed their diabetes independently. We found that this person's glucose monitoring was

inconsistent. We found two books with recordings in for this person. One book was old and partially completed and the other was current. We asked the person about their glucose monitoring. The person told us; "I can't see where to write things and I don't know where to write it". This was highlighted to staff who told the person; "You should have told us if you can't see it". This evidenced a lack of oversight or supervision of this person's diabetes.

Another person who had started to independently manage their diabetes was hoping to eventually develop independent living skills in order to move on from Waterloo House. This person had no record of how their independence was being monitored in relation to diabetes. This meant the person's ability to manage their condition independently was not being assessed.

We noted there was a lack of guidance for staff on what to do if a person's blood sugar became either too high or too low. This meant that staff may not have known what action to take to support people, should this occur. People's records suggested that they were not always having their condition regularly reviewed by their GP. For example, one person's care record indicated their last diabetic review with their GP took place in August 2013. Another person who had diabetes had very limited information within their care plan to guide staff on how to manage their condition... The only reference we found was from an old care plan from another service where the person had been prior to coming to Waterloo House. The care plan stated; "To be seen by the diabetic nurse". There was no further information in this person's care records. There was no evidence that this person's blood sugars were checked regularly to ensure they were stable and to ensure this person's health was maintained. We spoke with this person and they confirmed they had a yearly eye check and diabetes check. The person told us they took sweeteners in their coffee instead of sugar. We asked staff, who said the person made their own drinks and added; "loads of sugar". This evidenced that staff were not adequately monitoring this person's condition to keep them safe.

There had been a best interest meeting for one person, where it became apparent that they should have been having two drinks per day to ensure that their alcohol intake did not become problematic. This had been highlighted to the previous manager upon their admission, but had not been adhered to. Staff confirmed that the person had been having far more than this. During the best interest meeting it was decided that the person should have their alcohol intake reduced to the two drinks suggested upon admission. There was no plan around managing this withdrawal process and staff expressed concern for how they would manage both the physical and behavioural aspects of this. Staff had not undergone training in detoxification. One staff member said; "We were not told that [person's name] was only meant to be having two alcoholic drinks per day. We should have been told. We have been fuelling [person's] problems and it isn't fair".

Staff we spoke with were committed to undertaking training and to improving their knowledge and skills. Staff confirmed that they had received an induction and were supported by six monthly face to face supervision and an annual appraisal. We found some documentation to reflect this in their personnel files.

People told us they enjoyed the meals. We observed the lunchtime experience. One person said; "Oxtail soup, my favourite" and another said; "The food here is really good". People appeared comfortable and content and there were enough staff on duty to assist people if required. The food appeared appetising and plentiful. We saw a menu plan in the kitchen which evidenced that there were alternatives on offer. One person had a gluten free diet and this was recorded in the kitchen and the cook ensured the person's diet was appropriate. We were advised that people did not contribute to the menu plan and as there were no residents meetings or quality questionnaires it was not clear whether people's views on what was offered were actively considered.

People's bedrooms were spacious and personalised. One person said; "I like it here. My room is nice and I have a warm bed at night". The bedrooms we viewed appeared clean and comfortable. People accessed the rear garden of the service. A number of the people living at the service were smokers and would go outside into this area to smoke. We observed that as the doors to the garden were often left open, and people stood close to the building whilst smoking, the cigarette smoke would blow into the lounge area, making it smell strongly. This may not have suited the needs of those living at Waterloo House who were not smokers.

Requires Improvement

Is the service caring?

Our findings

Some aspects of the service were not always caring.

People made some positive comments about living at Waterloo House. Comments included; "I like it here. It's very nice"; "I don't mind being here"; "Pretty good, quite attentive to people's needs" and "I feel alright here. No faults. I can go about doing things. There is nothing to change". Staff told us they enjoyed working with most people who used the service and were committed to providing good quality care. Staff were also committed to taking on new learning and to improving standards at Waterloo House.

We also received some negative feedback from people living at the service. One person we spoke with actively wanted to leave and was critical of the staff and care received. Some staff we spoke with were clear that they struggled to support some people living at the service and to deal with some of their behaviours. Two people we spoke with felt unhappy about a recent admission to the service and felt that their quality of life had been affected by the person's behaviours.

Staff did not know all of the people living at the service well. People's care records contained limited or out of date information to inform staff on their likes, dislikes, strengths or goals. This was particularly evident in relation to some of the new people who had recently joined the service. One person living at Waterloo House had limited verbal communication. Staff told us they did not know how to meet this person's needs, but told us the person did not appear to be happy.

We observed some positive interactions between people and staff. Some staff were seen to take time to chat with people and to share appropriate humour. Most staff were observed to speak with people in a calm and reassuring tone. We observed one staff member complimenting a person on how they were wearing their hair and the person reacted positively to this. However we also observed some interactions which were not positive. One staff member was seen to sit with their back to people in the lounge and switch television channels without first checking if people were watching something. Another person was complaining of pain from their legs and a staff member was seen to respond dismissively, telling us the problem had been looked into by their doctor and as they would not comply with the recommended treatment, there was nothing they could do.

People's confidential information was not always securely stored. One of the two volumes of care records were stored in a filing cabinet in the lounge. On day two of the inspection we found this cabinet to be unlocked and easily accessible. This was reported to staff and the cabinet was seen to be locked on day three. Confidential information about people's finances was stored within their care records. This meant that people's personal information was shared unnecessarily with staff.

Staff were generally observed to seek people's verbal consent before assisting them with aspects of their care such as eating or moving around the home. Staff were seen to knock before entering people's bedrooms.

People were not always given the opportunity to express their views and to be actively involved in decisions about their care. For some time, there had not been residents' meetings at the service. We were told that they were being reintroduced, and by the final day of our inspection, the first meeting had taken place. There was little evidence to suggest that people had been involved in the development or review of their care plans.

Most people's care records indicated whether they wanted their care to be delivered by a male or female member of staff, however, these forms were dated in 2014 and therefore people's preferences may have changed. We saw no evidence in people's files to suggest they had access to advocacy services.

Inadequate

Is the service responsive?

Our findings

The service was not responsive.

People had two sets of care records which were running concurrently. The records were disorganised and difficult to navigate. One set was stored in the office and the other, in a filing cabinet in the lounge. The records had not been recently reviewed to reflect changes in people's needs. Much of the information in the care records was duplicated. It was unclear as to which file was back up information and which was the working file. We found contradictory information between the two sets of records, making it difficult to gain an accurate picture of the person and their care needs. Staff we spoke with agreed that the system was confusing and disorganised and confirmed that they were working towards combining the two files to simplify the system.

Some care plans contained in people's records were significantly out of date. Some had not been reviewed since 2013. One person had displayed inappropriate behaviour towards female care staff. This had been recorded on an incident form. The outcome of the incident was recorded as; "to be done in pairs from now on". The care plan contained no guidance as to what this meant for staff. For example, it was not clear what the role of the second member of staff was. The person's care plan stated that advice had been sought on this matter from the person's doctor who had said they would look into the person's background and formulate an action plan for staff. There was no further information in the care plan since this entry in 2015. We looked at this person's other set of care records. These contained a letter from a locum doctor written in 2015, which contained information about a proposed treatment plan using medicines to manage this behaviour. The letter directed staff to administer medicines to this person, gradually increasing the dose and monitoring the effects on the person and on the behaviour. We found no evidence to suggest that this had been done. We checked the person's MAR charts and found that they were not currently taking the medicine. Staff were not aware of when it was stopped or whether it had ever been commenced. Staff confirmed that the person continued to display inappropriate behaviour towards female staff during care interventions.

Some people's care records contained a section entitled; "All about me". However, we found that the information within them was in a tick box format, mostly relating to dietary likes and dislikes and had not been recently reviewed.

The service had its own minibus. Staff told us that it was used to take people to appointments or on outings. Staff told us that outings were arranged on an ad-hoc basis. We found no record of when the last outing had taken place and people we spoke with were not clear. People did not have personalised activity plans in their care records and there was no programme of activities in the home. Staff told us that entertainment was arranged for special occasions. For example, that a "music man" would come in at Christmas which people enjoyed. One person told us there had been a recent Halloween party and that people had dressed up and a buffet had been arranged. During the three days of our inspection however, we saw no evidence of any activities taking place. Most people were either in their bedrooms, watching television or outside smoking throughout the inspection. At the first residents' meeting which was held during the time of the

inspection, people asked for more activities.

We found little evidence that the service was adequately ensuring that people were receiving care and treatment that reflected their personal preferences. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 9: Person centred care .

One person was very clear that they wanted to leave Waterloo House and go to live in a place where their physical health needs would be met. This person complained; "The negligence was terrible" and that they would; "Rather be dead than be somewhere like this". The person wanted to be seen by the GP due to shortness of breath, a persistent cough and sore throat. Staff told us that the person was due to see their GP and an appointment had been arranged. There was no evidence of this in the person's records. It was difficult to gain an understanding of how this person's health needs were managed and monitored. There was no evidence of regular GP input, despite staff saying that they regularly saw their GP. The person's records indicated blood tests were taken on 6 October 2016, but there was no record of the results or of any treatment plan. We were unable to find any evidence of recent health checks for this person.

The service did not always respond appropriately in relation to people's specific needs and behaviours. For example, Some people living at the service were known to be alcohol dependent and to consume alcohol. Staff told us that some people would become intoxicated and engage in risky behaviours such as crossing busy roads, or taking their clothes of and accessing shared parts of the service naked. There were no plans in place on how to manage the alcohol dependency or associated behaviours. Staff told us that some people would obtain alcohol by asking, or persuading other people living at the service to buy it for them. There was therefore no real oversight of how much alcohol was being consumed and no monitoring of the health and safety concerns associated with this.

We observed another person who would repetitively access the drinks station to drink cups of milk. The behaviour continued very frequently throughout most of the day, meaning that very large amounts of milk were consumed by this person. There was no oversight of this by staff. This person's medical history was incomplete and it was not known whether consuming large amounts of milk may have been harmful to them. In addition to the underlying cause of this behaviour was not being assessed, meaning that it was not possible to determine if this person's needs were being adequately met.

We found incident forms for another person, stored in one of their two volumes of records. The forms contained information about aggressive behaviour. There were three entries made in 2014. The actions for staff were recorded as; "Inform management". There were no further plans following those events, such as a behaviour plan or review of the person's medication. No other risk assessments or care plans were found.

Care records were sometimes contradictory. One person's records suggested that they had a catheter in situ. We were not able to locate information around when this was last checked or when it was due to be changed. There was no recording by district nurses around when they had last done this. We asked staff for information around this. We were told that the person no longer had a catheter, and now wore pads. This meant that understanding people and their needs was difficult and may have led to confusion for those supporting them.

There had been a number of recent admissions to the service who had complex needs. Some staff raised concerns about the suitability of the service to meeting their needs. One staff member said; "[Person's name] needs somewhere else" another said; "Morale is low. People don't want to work here. We are mentally drained by these [new] people". Care plans and risk assessments for these people contained limited information and the assessment of their needs prior to coming to live at the service did not represent

an accurate picture. This raised concerns around the home's pre-admission process and around how decisions were reached that the placements were appropriate. One staff member said of one of the new admissions; "We don't know what to do to help [person's name]. It's not nice to see them like this" and of another of the new people, "We don't know why [person's name] is here. As far as we know, they don't have a mental health problem".

There was information around how to make a complaint which was located in the entrance hall to the service. There was also a complaints policy in place. We were told that there were no current complaints and that the most recent had been made in 2011. One person we spoke with confirmed that they would feel comfortable making a complaint if necessary.

Inadequate

Is the service well-led?

Our findings

The service was not well led. There was no registered manager in post. A new manager had been appointed and was due to commence their role in early December 2016. In the meantime, the deputy manager from another service was attending the home to begin to undertake some of the action needed to make the service safe. We were concerned about the sustainability of this arrangement and about the ability of one staff member to address the significant areas of concerns in a timely manner. This was highlighted to the provider and they were in the process of appointing some temporary nursing staff to assist the deputy manager. A new, full time manager had been appointed to begin working at the service in December 2016.

Some staff we spoke with were feeling apprehensive about managerial changes and unhappy about a number of recent admissions to the service. One member of staff said they felt; "drained and daunted" by the task of caring for one particular person. There had been no staff meetings at the service for some time and therefore opportunities for staff members to raise concerns such as these, and to offer each other support and share ideas for managing complex individuals were missed.

People were not able to share ideas about the running of the service, because there were no residents' meetings and there had not been a cycle of quality assurance for around two years. We highlighted this to the managers on day two of the inspection and by day three, they had begun to circulate questionnaires amongst people, the first seeking their views on the meals provided at the service. A residents meeting had also been held and people had shared ideas and concerns. People had said they wanted more activities within the home and this was being considered. One person had requested a new carpet in their bedroom and we were told this would be provided.

Accident and incident forms were poorly recorded and stored in people's care records without being audited. A number we looked at were not dated and did not specify what the outcome had been. These forms were not audited which meant that not only was the poor quality of recording overlooked, but also the opportunity to look for themes which may have reduced the likelihood of a reoccurrence was missed. People's care records were not audited, meaning that out of date, missing or innacurate information was not identified by staff.

We asked managerial staff for evidence of any recent audits which had taken place to monitor the quality of the service. We were told that there were none. One staff member said that medicines were audited but that this process was not documented. If the audits were taking place, they had failed to identify the issues with medicines management we observed. These issues were highlighted to the deputy manager and provider and we were assured that a new system for recording, monitoring and auditing accidents and incidents would begin immediately; however this had not yet been implemented by the time another agency visited the service a week later.

Consistent with the significant number of concerns and breaches in regulations outlined in this report, it was evident that quality assurance systems were not satisfactory.

This was a breach of Regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

The registered provider was registered with the Care Quality Commission (CQC). The provider is required by law to submit notifications to CQC of significant events such as injury or any safeguarding concerns.

We found the service had not submitted statutory notifications as required. This was a breach of Regulation 18 if the Care Quality Commission (Registration) regulations 2009.

Staff said overall there was a positive culture at the service. Comments from staff included; "It's like a big family and we support each other" and "There is low sickness and staff turnover. It's like a family here". Staff were committed to undertaking training to assist them in their role. One staff member said; "I was meant to have medicines training. I wanted to do it, but it wasn't arranged". Staff also told us they would like role specific training, for example, around personality disorders.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents We found the service had not submitted statutory notifications as required

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care We found little evidence that the service was adequately ensuring that people were receiving care and treatment that reflected their personal preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity was not assessed and best interest processes were not followed in line with the principles of the Mental Capacity Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Staff had not always reported signs of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 15 HSCA RA Regulations 2014

personal care

Premises and equipment

The service was not using the appropriate level of security needed in relation to the premises and equipment