Daughters of Mary Mother of Mercy

Waverley Care Home

Inspection report

14-16 Waverley Road
Sefton Park
Liverpool
Merseyside
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Tel: 01517274224

Date of inspection visit:
15 November 2023

Date of publication:
30 January 2024

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Waverley Care Home is a large 3 story building. The service supports people with nursing needs. The service is registered to accommodate up to 20 people. At the time of the inspection, there were 11 people living at the home.

People's experience of the service and what we found
We found high level concerns with regards to the premises and the equipment. Most areas of the home required repairs and some areas potentially put people at risk of significant harm. Hot water temperatures in sinks in people's rooms and bathrooms were running above the required temperature, and fixtures and fittings, such as curtains in bedrooms, and paintwork, was in a poor state of repair. The dining room was not being used for its intended purpose and was being used as a storeroom. This meant people only had access to one communal area.

There was limited oversight regarding any maintenance work. Actions issued from a legionella risk assessment in March 2023 had not been completed, and there was no one checking maintenance jobs had been reported or actioned. Some records required improvement, there was no organised system to track and monitor DoLS applications, which meant that we could not be sure if DoLs had been applied for appropriately for people. There was no incident and accident analysis taking place, which meant we could not always be certain mitigation had taken place as a result of incidents. Therefore, we could not be sure lessons had been learnt from shortfalls in care provision.

There had been some improvements since the last inspection in relation to clinical care plans and medication. The provider had also made some improvements in relation to fire safety and staffing at the home.

People were looked after and staff were observed to care for people. However, due to there being a lack of space, because the dining room was not being used for its intended purpose, the home felt institutionalised in its approach. The dining experience was poor and the food was not presented nicely and did not look appetising.

People were mostly supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. However, some records in relation to DoLS required improving.

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

Rating at last inspection and update
The last rating for this service was Inadequate, published 15 December 2022. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection

we found the provider remained in breach of regulations.

Why we inspected
When we last inspected Waverley Care Home on 27 October and 1 November 2022 breaches of legal requirements were found. We also issued a warning notice. This inspection was undertaken to check whether they were now meeting the legal requirements and to follow up the warning notices. We undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to infection prevention control, premises and equipment, records and governance.

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

Special Measures
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Waverley Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
This inspection was carried out by two inspectors and an operations manager.

Waverley Care Home is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement dependent on their registration with us. Waverley Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager still registered with CQC. However, they had recently left employment with the service.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us

to give some key information about the service, what the service does well and improvements they plan to make.
We used all this information to plan our inspection.

During the inspection
We spoke with 4 members of staff, the deputy manager administrator and a professional who visited the service. We reviewed a range of records. This included 5 people's care records and multiple medication records. We looked at 3 recruitment records, and other records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question Inadequate. At this inspection the rating has remained Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had made some improvements in relation to people's clinical risk assessments. However, risks to people remained as regular health and safety risk assessments of the premises and equipment were not undertaken.

● We saw action and learning had not taken place since our last inspection when we highlighted concerns with the premises and environment. Whilst we acknowledge some concern, in relation to fire risks, had been acknowledged and acted upon, we found other significant concerns with the premises and equipment at the home.
● Rooms were unkept, some window ledges were mouldy and curtains were hanging off fittings not covering the windows adequately.
● There was no maintenance person in post, and we saw outstanding jobs such as holes in the ceiling which had not been fixed. There was a large gap between an external door and the frame, adjacent the kitchen leaving the area exposed to potential vermin, as well as the doors being ineffective in the event of a fire.

● One bathroom had a broken bath panel, with a sharp corner which could cause a skin tear if someone brushed past it. The radiator cover in the same bathroom was not fixed to the wall, and fell off when we touched it. This means it could potentially injure someone living at the home.
● The main staircase leading to the lower ground of the home was coming away from the wall, and easily accessible to people on the ground floor as it did not have keypad access. This meant someone could injure themselves on the staircase.
●People only had communal access to 1 small lounge area. This was because the dining room was not being used for its intended purpose, and was being used as a storage room, which posed a fire risk and also meant there was a lack of space in the home.
● The lounge people sat in, ate in and completed activities in had electrical plug socket wires trailing across the floor, meaning people were at risk of tripping over, and ripped chair covers, meaning people were at risk of cross contamination as the chairs were not able to be cleaned effectively.
● Water temperatures were out of the required range, and no action had been taken, which meant people were at risk of scalding.

These examples highlight a breach of Regulation 15 (premises and equipment) of the Health and Social Care 2008 regulated activities (Regulations) 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong;

● People told us they felt safe at the home, and staff knew how to report concerns.

We provided feedback to the deputy manager and home administrator on day 1 of our inspection, so they could start taking some remedial action to ensure people were safe.

Staffing and recruitment

At our last inspection the provider was in breach of regulation 18 of the Health and Social Care Act 2008 Regulated Activities (Regulations) 2014. This was because staffing levels were insufficient. We saw during this inspection the provider had made improvements and was no longer in breach of regulation.

● The provider ensured there were enough staff on duty. There was 11 people living at the home. No one told us there was an issue with staffing. The deputy manager assured us as the numbers of people increased the staffing level would change accordingly, and we saw evidence from the deputy manager they only agreed to offer places to people if they could meet their needs.
● The provider operated safe recruitment processes, however there were some issues we fed back with regard to 1 person's reference and another person's employment history. This was addressed during our inspection.

Using medicines safely

At our last inspection the provider was in breach of regulation 12 of the Health and Social Care Act 2008 Regulated Activities (Regulations) 2014 in relation to medicines. This was because the provider had failed to manage people's medicines safely. We saw during this inspection the provider had made enough improvement and was no longer in breach of this part of the regulation.

● People were supported to receive their medicines safely.
● Creams were applied safely and people had an adequate stock of medication to ensure their pain was well managed.
● PRN protocols were in place for each person.

Ensuring consent to care and treatment in line with law and guidance

At our last inspection the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 Regulated Activities (Regulations) 2014. This was because consent and DoLs were not always appropriate. At this inspection the provider had made enough improvements to not be in breach, however we felt some further improvements were needed in this area

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 MCA 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the

Deprivation of Liberty Safeguarding (DoLS)

● The provider was working in line with the Mental Capacity Act, however some records with regards to the MCA required updating.
● We did not see any evidence the provider was unlawfully depriving people of their liberty.

Visiting in Care Homes
● People were able to receive visitors without restrictions in line with best practice guidance.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Inadequate. At this inspection the rating has remained Inadequate. This meant there were significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

At our last inspection the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities (Regulations) 2014 in relation to governance. We found during this inspection the provider had not made enough improvements and was still in breach of regulation.

● There were some audits in place however they had not effectively identified what we found during our inspection and were 'tick box' in nature. For example, we saw one recent audit which stated the dining room had tablecloths on the tables. There was no dinning room in use at the home since the COVID-19 pandemic.

● Area of the home were in a poor state of repair and there was no maintenance person in post. There was a person who came to the home on an ad hoc basis to complete jobs. However, job sheets had not been reported and filled in since July 2023.
●There was a legionella risk assessment in place which had been completed by an external company in March 2023. There were some high and medium risk areas identified which required action. However, not all the high and medium risk areas for action had been addressed and action plans updated. Following our inspection, we received assurances a quote had been requested for the work. This was only recent and had not been followed up. This meant we had limited assurances timely action was being taken to ensure people were safe.
● We were informed the provider did visit the home, and we saw a log of their visits summarised in a note book. Health and safety risk assessments were not taking place. Therefore we are not assured the provider has adequate oversight of the service.

At our last inspection the provider had failed to ensure records relating to people's care and treatment were updated or completed fully or accurately. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found during this inspection not enough improvement had been made, and the provider remained in breach of regulation 17.

● Records and oversight of people's needs were disorganised.
● For example, the provider was not analysing incidents and accidents. Therefore, there were missed

opportunities to mitigate harm exposing people to risk.
● We saw one person had fell 3 times in a short space of time, on one of the occasions they sustained a serious injury. The records regarding the incident were unclear and there was no further investigation into what happened and what could be done differently. This also means there was no opportunity to learn lessons when things went wrong.
● Records in relation to people's DoLs were not organised or kept up to date.
● We saw one person's DoLs had expired, however, from the records there was no evidence this had been reviewed and applied for. We found from looking at email trails the DoLS had been renewed.

These examples demonstrate a continued breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities (Regulations) 2014.

● Notifications had been submitted in line with regulatory responsibility and the rating from the last inspection was displayed in the communal area.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

●There was not always a positive and open culture at the service.
● The provider did not always have effective practices and procedures in place to provide person-centred care that achieved good outcomes for people. People mostly sat in the lounge all day, and the atmosphere was not furnished or kept to a good standard.
● People we spoke with said they just mostly sat in front of the television. The dining experience we observed was very institutionalised and there was no opportunity for people to sit at tables and chat.
●Food was also poorly presented. We saw broccoli being served out of an empty water jug, which did not look appetising.
● The staff were clearly motivated enough to ensure people's needs were met, and we did see staff speaking to people kindly and asking them if they needed anything. One staff member told us "We are like a big family."

Working in partnership with others
● The provider worked closely with the local authority commissioning teams.
● The provider attended local provider forums.