Watermoor House RCH

Watermoor House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Watermoor House is a residential home for older people some of whom live with dementia. Accommodation is arranged over three floors for up to 39 people. There were 35 people living at the service at the time of our inspection.

People's experience of using this service:
People's medicines were not always managed safely. There was not a robust system in place to support people with their topical creams and lotions. The protocols in place to support the use of 'as required' medicines were not clear. Safe systems were not in place to return unused medicines to the pharmacy.

People were not being supported by staff who had been recruited safely. We found gaps in employment history that had not been checked and the provider did not ask staff to complete a health check. The provider was not carrying out the required 'right to work' checks prior to staff starting their employment.

The management team did not routinely review accidents and incidents. This meant that risks had not always been reviewed so that safety measures could be put in place.

People told us they felt safe living at the service. Staff told us they understood safeguarding and knew how to report their concerns. We found one incident of potential safeguarding which had not been reported to the local authority or us.

Quality monitoring was not effective in identifying or driving improvement at the service. There was not an open and transparent culture at the service. There was a lack of management response to some concerns raised by staff. We received concerns about management approach prior to our inspection and following our inspection. The registered manager told us they had been dealing with staffing issues for a long time and was finding day to day management difficult.

Rating at last inspection: At the last inspection in November 2018 (report published December 2018) this service was rated as Good.

Why we inspected: This inspection was prompted by two whistle-blowers and other concerns received since the last inspection. This was a focused inspection to review the key questions 'Safe' and 'Well-led'.

Enforcement: We have found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to the more serious concerns found during inspection is added to reports after any representations and appeals have been concluded. We will meet with the provider to discuss our findings in this report. Full details can be found at the end of the report.

Follow up: We will continue to monitor this service and plan to inspection in line with our inspection

schedule.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

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.

Watermoor House

Detailed findings

Background to this inspection

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

The inspection was prompted in part by concerns we had received about the management of the home, so we focused on the key questions, 'Safe' and 'Well-led'.

Inspection team: The inspection was carried out by two inspectors.

Service and service type:
Watermoor House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was carried out on the 6 June 2019 and was unannounced.

What we did:
Prior to the inspection visit we gathered information from a number of sources. We looked at the information received about the service from notifications sent to the Care Quality Commission. We also looked at information received from the public and whistle-blowers.

During the inspection visit we spoke with three people, 11 members of staff, the registered manager and deputy manager. We looked at three care plans, medicines administration records, health and safety records and six recruitment files. We also looked at other management related records such as audits and

accident monitoring.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This means some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Using medicines safely
•People's medicines were not being managed safely and people were not always receiving their medicines as prescribed. We saw that one person had no pain relief in stock. Staff had recorded on their medicines administration record (MAR) that there was no stock available. There had been no stock available for the previous day. The person had received one dose from the home's 'homely remedy' stock. Whilst this had been recorded on the 'homely remedy' record, the staff had not recorded this administration on the person's MAR. This increases the risk of error. We were informed the person's pain relief would be available later during our inspection.
•Systems were not in place to dispose of medicines safely. We observed there was a jar in the medicine cupboard half full of unmarked tablets. A book recorded the dates and statements of where the medicine had been found. For example, staff had recorded 'found tablet on floor in corridor'. These medicines were waiting to be returned to the pharmacy. National Institute for Health and Care Excellence (NICE) guidelines recommend that care home staff record accurate details of all medicine-related incidents. This would enable records to be available for further investigations, reporting and monitoring for trends. We discussed this with staff to find out if they carried out any investigation into the numerous medicines that had been found in the environment, they had not. The registered manager told us they would make sure staff carried out an investigation if they found medicines which had not been taken.
•People who were prescribed topical creams and lotions did not have accurate records kept demonstrating they received their medicines as prescribed. Staff had recorded on people's MAR that staff were to sign a topical medicines administration record (TMAR) when they applied creams and lotions. TMAR were kept in people's rooms so care staff could sign following the application of the cream. This system was not robust. We found some people had TMAR in their rooms, but some people did not. TMAR seen had gaps in recording. Some staff were signing the TMAR some were signing the MAR. There was no confirmed system in place to ensure consistency in recording. We raised this with the registered manager during our inspection.
•Where people had been prescribed 'as required' PRN medicines there was no detailed protocols in place to guide staff to know when to administer this type of medicine. For example, one person was prescribed morphine sulfate oral solution to be taken when required. The dose was for up to 10mls three times a day. There was no guidance for staff to know when to give this medicine or how much to give. We saw the person had been given doses of this medicine. Staff had recorded the amount given, some doses were for 5mls, some were for 10mls. We discussed this with staff during our inspection who told us that a recent audit carried out by a pharmacist had also raised this issue. The staff told us they planned to review their PRN protocols.
•Handwritten entries on MAR had not always been signed by two members of staff. At the front of MAR

folders there was clear direction for staff to make sure two members of staff checked and signed every handwritten entry. This guidance had not always been followed, we found some handwritten entries had no staff signatures or one staff signature. When staff record by hand entries on MAR best practice is to sign each entry and confirm the information recorded by a second member of staff.
•People who had been prescribed medicine to be given using a patch did not always have a record in place for staff to know where on the body the patch had been administered. We saw that for one person there was no record in place of where the patch had been placed. We also saw there was a gap in recording on their MAR for their most recent application of patch. Staff told us this patch had been applied and amended the MAR.
•We found one person who did not have a MAR profile form in place. People had a MAR profile with their picture on, details of any allergies or other key information the staff administering medicines may need. One person had been prescribed eye drops which the staff were administering. There was no MAR profile available for this person. This increases the risk of medicines errors.
•Paraffin based creams and emollients had not been risk assessed. Whilst safe to use paraffin-based products can become flammable if they come into contact with an ignition source. We asked the registered manager to address this without delay. Some creams and lotions had no date of opening recorded on the containers. Once opened it is good practice for staff to know when the product will expire.

Due to poor medicine management systems people were placed at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

•Staff checked the temperatures of rooms where medicines were kept. Records demonstrated that temperatures of rooms and fridges were in a safe range.
•Staff received training prior to being able to administer medicines and their competence was checked annually.

Assessing risk, safety monitoring and management
•Incidents and accidents had not always been investigated to ensure appropriate action had been taken. We saw one incident form that stated a person had fallen in May 2019 and had been found between their bed and bedside table face down. The person was unable to state how they had got there. The person sustained injury to their face with swelling under their eye. We saw that staff had not attempted to seek medical advice or assistance despite the person presenting with facial injuries and potential head injury. Instead the person was hoisted back into bed. No documented checks or observations were put in place. The registered manager was initially unaware of this incident when we raised it and asked that it be investigated. Following our inspection, the registered manager sent further information relating to this incident. The information stated that observations had not been conducted and staff had been spoken with about this. The incident had not been correctly reported and recorded by staff. The registered manager further informed us that staff had not felt this was a head injury so had not sought further advice. This service is not however a nursing home and staff do not have clinical skills in making this judgement.
•There was a lack of understanding around what constituted a behaviour that could be challenging in its presentation. We were informed by the registered manager at the start of the inspection that they did not have anyone with such behaviours. However, on speaking to staff it became apparent that they were supporting people with these types of behaviour on a regular basis. One staff told us "[Person's name] is most challenging, they name call a lot to other residents and shout. We record it on a behavioural chart for the mental health team to review, we know the triggers." Another staff member told us "One person does not like personal care and will whack their call bell against us." Some staff had not received training to give them the skills required to support people who may experience distressed reactions.
•We reviewed the behavioural incidents that staff had recorded and found that these did not always reflect an appropriate response had been taken. For example, one person's behaviour record documented they

had been hitting, spitting, screaming, threatening, and using their call bell as a weapon. The actions taken by staff were recorded as, asked to stop politely and explained the need for their actions (giving personal care). There was no other information around if the person had calmed or if they had tried other methods or if it was a successful outcome.
•The provider's policy on challenging behaviour stated that detailed risk assessments should be created to ensure possible dangers which are presented are considered and reduced where possible. The manager should fill out an incident form and ensure that a full note of events has been made in the individuals notes by member of staff. This had not been effectively followed.

Due to the lack of risk assessment and management people were placed at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Learning lessons when things go wrong
•Staff were not learning from near misses or incidents at all opportunities. We saw in people's notes incidents that had occurred with regard to people's behaviour. These incidents had not been recorded on incident forms which meant they were not included in any analysis carried out by the management.

Staffing and recruitment
•People were being supported by staff who had not had the required recruitment checks carried out prior to starting work. We found the service had not obtained a full employment history and explanation of any gaps for all the staff files we checked. For one member of staff we found there were two gaps in employment which had not been explored. We found another staff file with two gaps in employment history, one of which was for over two years. This had not been explored. For one member of staff we saw there was an application form and a CV on their file. The job history and dates of employment on these records did not match. This meant there was a discrepancy with information supplied by the member of staff which had not been verified.
•The provider had also not checked that all staff were physically and mentally fit to carry out their roles.
•The provider had not completed 'Right to work' checks as required by the government's guidance to make sure employees were able to work in the UK. Employers need to check all job applicants original right to work documents. The employer must take a copy of the document, verify it and record the date of the check. We informed the registered manager of all these shortfalls during our inspection.

The lack of robust checks before staff started working in the home placed people at risk of harm. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Staff had received a check with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and to avoid unsuitable people working with vulnerable people.
•There were sufficient numbers of staff to meet people's need. During our inspection we observed that call bells were not ringing for prolonged periods of time and staff were available to help people when needed. The care team were one member of staff short but the deputy manager helped when needed.
•The staff rota had undergone adjustments with the shift times changing to 7am to 7pm. Gaps in staffing were currently being covered by agency staff whilst recruitment was ongoing.
•Staff told us they thought there was enough staff at the service but there were times when it could be improved. This was when there was unplanned absence. Comments included, "There is enough staff, you are always going to have sickness and annual leave. I do some care shifts and do nights, we are all links in a chain", "We have enough staff, some days are more hectic, but we have time to spend with people" and "We have enough staff, it is annual leave time, one short today. We used to have a lot of agency but not today and other staff help out when they can."

Systems and processes to safeguard people from the risk of abuse
•An allegation of abuse had not been managed or investigated appropriately. One person had raised concerns in March 2019 that they had been locked in their room. They had said as they had been shouting that staff did not want to listen to this. There was no record that this allegation had been taken seriously, or further investigated. No notifications had been made to the safeguarding team or CQC. We requested that the manager investigate this further immediately.
•People told us they felt safe at Watermoor House. One person told us, "I feel safe, I have no concerns at all. It's my home and I treat it like that and staff treat me as if this is my home."
•Staff told us they had received safeguarding training and we confirmed this from training records. Staff were aware of the option to take concerns to agencies outside the service if they felt they were not being dealt with. One member of staff told us, "If we have concerns about residents we put safeguarding in place to protect them. I have never seen any concerns. I would tell my team leader. I have heard of whistleblowing and if something happened I would do that, it's my duty of care."

Preventing and controlling infection
•People lived in a service that was kept clean with no malodours present. People told us they were happy with the cleanliness of their rooms.
•Staff were observed to use personal protective equipment appropriately and follow good practice in relation to infection prevention and control.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. There were significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

•Quality monitoring systems were not effective in identifying action required to improve the service. We were not confident information recorded within some audits was accurate therefore the service did not have an accurate overview of shortfalls. For example, within a health and safety audit, it was recorded that all day staff had taken part in fire drills within the previous six months. It was recorded that all night staff had taken part in fire drills within the previous three months. The registered manager was not able to tell us where the information to record these findings had come from. There were no records of staff having taken part in fire drills.

•Medicines audits had recorded that the service was compliant with the provider's policy on managing topical creams. This is not what we found. The provider's policy for returning medicines to the pharmacy was not always being followed by staff.

•We found one allegation of potential abuse which had not been investigated or reported to the local authority. We asked the registered manager to look into this incident without delay.

•A complaints procedure was on a notice board by the front door. This procedure informed people and visitors that if they were not satisfied with how the service managed their complaint they could complain to CQC. This is not correct, the CQC do not investigate individual complaints. We asked the registered manager to remove this and give people the correct information.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

•People were able to attend 'residents' meetings' where they could share their views about the service. Minutes were kept recording the discussion. Within the minutes for February 2019 we saw people had raised some issues which required further action. For example, people had raised concerns about the outside lights and wanted to know how to use a new hearing loop in the lounge. There had been no action plan produced or any other record of what action was needed, who was to carry it out and by when. Within the minutes for the following meeting there was no 'matters arising' or reflection on previous meetings to discuss actions taken. We asked the registered manager who told us they did take action as required. They had not recorded this or shared it with people. Following our inspection the provider sent us information to demonstrate how they had taken action in response to people's feedback. They also told us they would put into place formal systems to record actions required following 'residents meetings'.

Planning and promoting person-centred, high-quality care and support with openness; and how the

provider understands and acts on their duty of candour responsibility
•Prior to this inspection we had received two whistleblowing concerns that the culture in the home of management and staff was not positive and this was having a detrimental effect of people in the home. Following our inspection, we have continued to receive information about this poor culture.
•The management made us aware that there were disciplinary investigations going on with some staff. They also said they had ongoing grievances with some staff which impacted on the management of the service and caused personal anxiety. The registered manager told us "Changing the culture has been tough work when you are just one person."
•There was not an open culture at the service. Staff raising concerns did not always have them investigated by management. We reviewed staff team meetings and saw staff working relationships had been discussed but not resolved. In April 2019 it was recorded that one member of staff's attitude was upsetting other staff. This staff had then proceeded to make a threatening statement directed towards other staff. Whilst this incident was dealt with we are concerned there was no risk assessment completed to mitigate any risks. We are also concerned about the working relationships some staff have with each other which results in a threat of violence.
•A meeting chaired by the registered manager in March 2019 discussed with the staff how gossip was causing problems on a daily basis. Staff were told to come to the office and speak with management and if it carried on there would be disciplinary action.
•We saw however in a further team meeting in April 2019 that staff continued to raise issues including inappropriate staff behaviour. One staff raised concerns that they felt bullied and harassed. The team leader chairing this meeting instructed staff to report their concerns to the management and moved onto the next agenda item. The team leader did not raise the issues with management. The management team told us they had reviewed the meeting minutes; however, these had not been followed up to ensure that there was not a bullying culture within the home. This meant some staff had been left vulnerable in the workplace through ineffective leadership.
•Management and staff were not working together to provide high quality care. The registered manager told us they had been dealing with staffing issues for a long time which had prevented them from dealing with other management work. They were not confident the provider understood the scale and depth of the shortfalls at the service.
•Prior to our inspection we received some concerns regarding staff behaviour and the management response to this behaviour. We asked the provider to investigate. The provider asked the deputy manager of the service to investigate these concerns. This meant the deputy manager was investigating the behaviour and approach of the registered manager. We raised concerns about this with the provider as we did not feel this was open, transparent or appropriate.

Continuous learning and improving care
•Systems in place were not always effective in driving improvements. Accident forms were being audited, but we saw this consisted of a list of what had happened. There was no analysis, no identifying patterns or trends to make improvements.

The failure to assess, monitor and improve the quality and safety of the service placed people at risk. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Working in partnership with others
•Details of local advocacy services were available in the service for people to use if they needed that type of service.
•Local clergy visited regularly to support people with their religious needs where appropriate. People were also supported to engage with activities provided by services from the local community.

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 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not managed safely. People's risks had not always been identified, assessed so that appropriate safety measures could be put into place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The required pre employment recruitment checks had not always been carried out by the provider for all staff.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality monitoring systems were not effective in identifying and driving improvement at the service. There was a lack of overall governance of the service. Management did not have an oversight of shortfalls and were unaware of incidents, accidents and staff concerns.

The enforcement action we took:

Impose a condition on the providers registration.