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Waterfall House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 4 April 2018 and was unannounced. At the last inspection on 25 February 2016, the service was rated Good. At this inspection we found the service remained Good.

Waterfall House is a residential care home for up to 18 people with mental health needs. At the time of this inspection there were 11 people living at the service. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At our last inspection we rated the service 'Good'. At this inspection we found the evidence continued to support the rating of 'Good' and there was no evidence or information from our inspection and on-going monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

People told us and we observed that they were happy and settled living at Waterfall House. Some people had been living at the home in excess of 25 years.

Risks associated with people's health, medical and social care needs had been identified and assessed to ensure people were supported to reduce or mitigate the risk in order to keep them safe and free from harm.

People and relatives confirmed that they and their relatives were safe living at Waterfall House. Care staff demonstrated a good understanding on how to recognise and report suspected abuse.

The service followed robust processes to ensure the safe management and administration of medicines.

We observed sufficient staffing levels in place which met the needs of the people living at the home.

The service followed their recruitment policy in order to ensure that only staff assessed as safe to work with vulnerable adults were employed.

Care staff told us and records confirmed that they were appropriately supported through training, supervision and annual appraisals.

Pre-admission assessments were comprehensively completed to ensure that people's needs, choices and preferences were discussed so that the service could determine whether they were able to meet people's identified needs.

Care plans in place where person centred and clearly reflected people's needs, choices and preferences. These were reviewed regularly.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People's nutrition and hydration needs were appropriately met and took into account their choices, preferences and any specialist dietary requirements. People were supported with their nutrition and hydration needs where required.

People and relatives knew who to speak with if they had a complaint and were confident that the issues that they raised would be appropriately addressed.

At the last inspection the service did not keep records of the checks that they completed to monitor the quality of care people received. At this inspection the service had addressed this issue. The provider had a number of processes in place to monitor the quality of care in order to learn and improve.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Waterfall 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 comprehensive inspection took place on 4 April 2018 and was unannounced.

One inspector and one inspection manager carried out this inspection with the support of two experts by experience who spoke to people at the home and made telephone calls and spoke with relatives of people using the service. An expert-by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection, we reviewed the information that we held about the service and the providers including notifications affecting the safety and well-being of people who used the service and safeguarding information received by us. We reviewed the Provider Information Return (PIR) which the provider had sent to us. A PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make.

During our inspection we spoke with six people who used the service and four relatives. We observed interactions between people and staff. We also spoke with the registered manager, one senior care worker and three care workers. We looked at five care records, four staff and training records, five medicines records and records relating to the management of the service such as audits, policies and procedures.

Good

Is the service safe?

Our findings

People told us that they felt safe living at Waterfall House. One person told us, "Yeah, I have been here 20 years. Social Worker wanted to move me, but I said no I like it here." Relatives also confirmed that they believed their relative to be safe in the care of Waterfall House.

The registered manager and care staff that we spoke with demonstrated a good understanding of how to recognise and report suspected abuse. Staff also knew the meaning of the term 'whistleblowing' and knew that they could speak with external agencies such as the Care Quality Commission (CQC) or the local authority to report any concerns without fear of recrimination.

The service continued to complete and periodically review risk assessments which identified and assessed people's individual risks associated with their health, medical, care and social care needs. Risk assessments were comprehensive and detailed the risk, the objective in managing the risk and the actions required. Identified risks included smoking, nutritional risks, falling, going out and risk if harm to others.

We observed sufficient staffing levels present within the home. The registered manager explained that staffing levels were adjusted based on observations of people and any noted changes in their level of need. Where people required support and assistance accessing the community, the rota was adjusted to ensure a staff member was available to accompany the person.

Staff files that we looked at confirmed that the provider followed robust recruitment processes to ensure that only care staff that had been assessed as safe and suitable to work with vulnerable adults were recruited. Checks included criminal record checks, conduct in previous employment, identity verification and the right to work in the UK.

The provider followed safe and appropriate processes to ensure people received their medicines safely and as prescribed. Records seen were complete with no gaps or omissions in recording. Controlled drugs were stored and managed appropriately. Controlled drugs are medicines that the law requires are stored, administered and disposed of by following the Misuse of Drugs Act 1971. The service completed daily and weekly medicine checks to ensure that people were being administered their medicines safely and appropriately.

Care staff told us and records confirmed that they had received medicines training. Observations of care staff were also completed as part of their induction process and periodically thereafter in order to assess their competency, however, these were not recorded. The registered manager told this that they would record these going forward.

We observed that the home was clean and free from mal-odours. Staff had been trained in infection control and had access to a variety of personal protective equipment including gloves, aprons and shoe covers.

We checked all food storage areas including the fridge and freezer and found that these were clean.

Processes were in place which ensured that people had access to food which was safe to consume.

The safety of the building was routinely monitored and records showed appropriate checks and tests of equipment and systems were periodically undertaken. Personal Emergency Evacuation Plans (PEEPs) were in place and the provider had a clear contingency plan in place to help ensure people were kept safe in the event of a fire or other emergency.

The service had only one recorded accident since the last inspection. Records seen detailed the accident and the actions the service had taken. The registered manager and deputy manager both stated that they always use daily handovers and staff meetings as an opportunity to learn and improve the quality of care people received. The registered manager told us, "I read a lot of magazines, caring articles and I tell them [care staff] when I bring things in."

Good

Is the service effective?

Our findings

People and relatives stated that they felt care staff who supported them and their relative were adequately trained and skilled to do their job. Comments included, "Yeah, good people" and "Yeah, first class." One relative told us, "They are perfectly skilled. I have never had an issue with this place."

Care staff confirmed that they were well supported through regular training, supervision and annual appraisals. All care staff including recently recruited staff had received an induction and training in topics such as safeguarding, first aid, Mental Capacity Act 2005 (MCA) and risk assessments. Training was seen to be refreshed regularly so that staff were kept abreast of any legislative changes or changes in practise. Records confirmed that staff received regular supervision and an annual appraisal. One staff member told us, "We talk about the managerial role, how I interact with residents and how I can progress."

People's needs and preferences were always assessed prior to the admission of the person to the home, to ensure that the service could effectively meet their needs. The comprehensive assessment covered people's general health, medicine, personal hygiene and special service needs. This assessment culminated into a comprehensive care plan which gave staff information and guidance on how to effectively support the person with their needs. Care plans were reviewed every month to ensure the information was always current and reflective of the person's needs.

People were supported with their nutrition and hydration needs, where necessary, which included maintaining a healthy and balanced diet. People were encouraged to maintain their independence in this area where practicably possible. Where people had specific cultural or specialist dietary requirements these had been documented and were adhered to. One person cooked for themselves and others living at the home. Menu's were planned and agreed upon by the people living at the home through regular residents meetings. During the inspection we observed people having their lunch. This was noted to be a positive experience for people where we saw people eating well and enjoying their food. One person told us, "They make me a meal, I am a vegetarian. I enjoy."

The staff team worked effectively within the service and in partnership with a variety of external organisations and health care professionals to ensure people received effective care and support which fully met all identified needs. Records seen included daily handover records and communication, completed by the care staff team, which detailed people's daily living activities and updates. We also saw specific communication records and referrals to the mental health team, GP and speech and language therapists where people had required specialist input for their health and care needs.

People had access to a variety of external health care professionals which included GP's, opticians, community psychiatric nurses and social workers. Each visit with any such professional was clearly documented with details of why the visit was required, the outcome of the visit and any subsequent actions that needed to be addressed.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be

deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that the service was meeting the requirements of the MCA 2005 and the Deprivation of Liberty Safeguards.

Throughout the inspection we observed all staff including the registered manager asking people for their consent and offering choices in every aspect of their daily living and care. All staff demonstrated a good understanding of the MCA and its key principles especially in respect of the impact this had on the people they supported. One staff member told us, "We have to talk to people. For example [person] does not have capacity on how to spend their finances but can make decisions on day to day choices that need to be made." Most people living at the home had capacity but where a person had been assessed as lacking capacity, this had been documented appropriately with a best interest decision and a DoLS authorisation in place to protect the person.

Care plans had been signed by people where the service had assessed the person's capacity and understanding to do so. Where people had not signed the care plan, relatives had been involved in the care planning process and had signed the care plan confirming this.

People's rooms had been adapted and decorated in line with the person's needs, choices and preferences. People's rooms were personalised with items of interest and personal belongings of their choice.

Good

Is the service caring?

Our findings

People and relatives told us that they found all staff to be caring. One person told us, "Yes. That is why they opened this home to take care of us all." One relative said, "They [care staff] are, most times I come someone is sitting there chatting with him [person]." We observed that people had established positive and caring relationships with each other and the care staff which were based on mutual trust and respect.

Some people had been living at Waterfall House in excess of 25 years and considered it to be their home. We observed people to be very settled in their surroundings and accessed every area of the home as and when they so pleased. People had been given keys to the home and were able to leave the home as and when they wished. Care staff knew the people they supported well and were very aware of their emotional, physical and mental health needs which enabled them to support people in a way that promoted person centred care. One care staff explained, "We use a person centred approach. Our care is different for each person depending on their behaviours and needs."

We observed people to be involved in every aspect of their care and support and care staff encouraged and supported people to maintain their independence at all times where practicably possible. One staff member told us, "People's choices and practises are respected." We saw records confirming that people were involved in the review of their care plan. One person recorded any updates, changes or self-observations within their own daily record and progress notes. Care staff understood the importance of supporting people in maintaining their independence at all times and observations noted throughout the inspection confirmed this. One care staff told us, "We let people do their own stuff. If they can't do certain things we then help."

The service had also in partnership with the person established daily rehabilitation programmes for people to follow based on their abilities and capabilities. This included undertaking their own personal care, cooking, tidying their room and attending appointments.

People told us that care staff always respected their privacy and dignity which included care staff knocking on their bedroom door before entering and maintaining their dignity whilst they were supported with personal care. One person told us, "Staff seem to treat you with dignity and respect! Yeah they are very good." We observed care staff knocking on people's bedroom doors before entering and asking people's permission before carrying out any particular task. One care staff told us, "We take their consent before doing anything. We give them [people] choices and we always knock on their bedroom door."

Care plans were reflective of people's cultural, religious and personal diversity and staff were clearly aware of people's individual needs and how these were to be met. We asked staff about supporting people who may identify themselves as lesbian, gay, bi-sexual and transgender (LGBT). Staff members responses included, "We respect people's choices. We deliver a person centred approach" and "For me everyone is the same. There is no difference. We are all equal."

Good

Is the service responsive?

Our findings

People's care plans were detailed and person centred. Since the last inspection the service had developed comprehensive life history books for most people living at the home which gave detailed information about the person's life history, their achievements, significant relationships, interests and hobbies and significant life events. The information obtained about people enabled care staff to provide care and support that was responsive to their experiences and needs.

People had been allocated a named member of care staff as their key worker. Key workers were responsible for ensuring that the persons care and support needs were being met as well as ensuring regular communication with the person, their family had any other health care professionals were established and maintained. Key workers maintained weekly progress notes which detailed people's activities and significant events and observations throughout the week. These documents were easily accessible to all staff and provided them with immediate and relevant information about the person and their needs in order to provide care that was responsive to their needs.

Where people expressed certain behaviours that challenged, care staff were provided with detailed guidance and structure on how to support the person with their behaviour that ensured their safety and ultimately took them into positive well-being.

The service ensured that people had access to advocacy services where this was an assessed need. The registered manager confirmed that they supported people to access advocacy services through their community psychiatric nurse.

People participated in activities as and when they wished. The service supported people with activities of their choice on a day to day basis. During the inspection we saw people and care staff engaging in activities such as dominoes and board games. People were also able to access the community as and when they chose which included visiting friends, going to the local shops and shopping. Comments from people about activities included, "Sometimes. The provider comes to talk to us. They are very good here always try and help me. I am very happy here" and "Snakes and ladders, ludo, bricks, dominoes. Now and again I join in not all the time."

People and relatives knew who to speak with if they had any complaints or issues and were confident that these would be addressed appropriately. The provider's complaints policy clearly outlined details on how to raise a complaint and the steps the provider would take to address and deal with each complaint. It was positive to note that the service had not received any complaints since the last inspection.

The service did not always specifically support people who had been assessed as requiring end of life care as they did not feel they were equipped or specifically experienced in this area. In this situation the registered manager normally referred the person to a service, normally a nursing home, where this need could be appropriately met. However, as part of the care planning process people's wishes around their end of life care were documented for the service to be aware of.

Good

Is the service well-led?

Our findings

There was a registered manager in position at the time of this inspection. 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.

People knew the provider and the registered manager and we observed people to be at ease and comfortable when they approached her. We also observed that the registered manager was visible around the home at all times including meal times supporting and encouraging people where required. One person told us, "The manager is very good, nothing is too much trouble." Relatives also confirmed that the knew the registered manager and that they were always available. One relative stated, "Yes I know who the manager is and I think she is understanding and caring. Easy to talk to. Really caring to residents and easy to talk to."

Care staff told us that the registered manager was always available and ready to listen. They told us that they were supported in their role through regular supervisions, annual appraisals, team meetings and handover meetings which was confirmed in records seen. All staff said that staff meetings and handover meetings were very useful and gave them the opportunity to reflect and learn as well as share their own ideas and experiences. One care staff said, "We meet once a month and we talk about how to deal with situations, how to understand people's needs and share experiences with other care staff and other homes."

The service completed a number of checks and audits in order to monitor the quality of care in order to learn and drive through further improvements where required. At the last inspection we found that these checks were not always recorded. During this inspection we found that the registered manager had taken note of our feedback and had recorded all checks that were completed with details of actions taken where issues were found. Areas that were monitored included health and safety, falls, care plans, medicines management and infection control.

Residents meetings were held every two months and gave people the opportunity to discuss a variety of topics which included menus, staff changes activities. Minutes recorded that each person in attendance at the meeting were given the opportunity to contribute. One person when asked if they attended these meetings and the topics discussed, responded, "Yes! The way they go about their business."

Annual satisfaction surveys were also sent to people, relatives and visiting healthcare professionals in order to obtain their views and feedback on the quality of the service they received so that the service could learn and improve from the feedback they received. Completed surveys were positive and no concerns had been noted. Comments recorded included, 'All staff have a welcoming presence' and 'Always keep me up to date with everything concerning my [relative].'

The service had notice boards and information stands around the home that provided a variety of information for people to access about matters that may affect them and their care needs. This included leaflets from the GP surgery, newsletters from mental health services and internet articles about health

issues. The service also worked in partnership with other agencies to support care provision. We noted that that the service maintained positive links with a variety of healthcare professionals and community services including psychiatrists, GP's, social workers, local churches and colleges. The service also worked in partnership with the providers other locations so that they could share and learn from each homes experiences.