Alpha Health Care Limited

Waters Edge Care Home

Inspection report

Stafford Road
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11 April 2019

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Waters Edge is a care home that accommodates 63 people in a purpose built residential home for the elderly. Support is provided on two floors. There are various communal areas, including lounges and dining rooms that people can access. The home also has an adapted garden.

People's experience of using this service:
At the last inspection in June 2018, the service was rated as Good overall.

The care people received was not always safe. Measures put in place to keep people safe were not always effectively implemented in the home. Records were not always up to date to reflect people's current needs. Individual risks to people were considered and reviewed when incidents had occurred. Staff raised concerns about staffing levels and these had not been reviewed to reflect changes made in the home. Safeguarding procedures were in place and these were followed. Medicines were managed in a safe way. Infection control procedures were implemented. Lessons were learnt when things went wrong in the home.

The provider had introduced a more robust system as a safeguarding concern had not previously been shared across the home. The action the provider had told us they had taken to keep people safe had not always been fully completed. There were audits in place which were effective in continually developing the quality of the care that was provided to them. Feedback was sought from people and relatives who used the service and this was used to make changes. Staff felt supported and listened to.
More information is in the full report.

Rating at last inspection:
Good (Last report published 14 June 2018)

Why we inspected:
We carried out this focused inspection as we received information of concern about the management of unwitnessed falls within the home.

Follow up:
We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

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?

Requires Improvement

The service was not always well-led
Details are in our Well-Led findings below.

Waters Edge 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. 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.

Inspection team:
This inspection visit took place on 11 April 2019. The inspection visit was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
Waters Edge is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection:
This inspection was unannounced.

What we did:
We checked the information, we held about the service and the provider. This included notifications the provider had sent to us about incidents at the service. A notification is information about events that by law the registered persons should tell us about. We also checked information we had received from external professionals including safeguarding reports. Prior to the inspection we requested information from the provider in relation to a specific incident that had occurred within the home. We used all of this information to formulate our inspection plan.

We spent time observing care and support in the communal areas. We observed how staff interacted with people who used the service. During our inspection we spoke with seven people who used the service, six members of care staff, the team leader, the deputy manager and the interim manager. We also spoke with five relatives. We did this to gain people's views about the care and to check that standards of care were

being met.

We looked at care records for eight people. We checked the care they received matched the information in their records. We also looked at records relating to the management of the service, including audits carried out within the home and staff recruitment.

Requires Improvement

Is the service safe?

Our findings

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

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.

Assessing risk, safety monitoring and management

- Since our last inspection, an incident had occurred in the home where a person had fallen unwitnessed and a serious injury had occurred. We contacted the provider who offered us reassurances and told us the action they had taken to mitigate further risks to people.
- The provider told us 'an assurance measure' was now in place to manage the communal lounge on the ground floor. They had not implemented this on the first floor. We checked this at our inspection. The management team told us they ensured a staff member was present in the ground floor lounge between 10am and 8pm to ensure people who were at risk of falls were supervised. When we arrived at the home at 9am we saw a person in the communal lounge and there were no staff present. Later in the morning, we again saw this person in the communal lounge without any staff present. We checked records for this person and they were identified as being at medium risk of falls.
- We discussed the management of the lounge with staff and they told us they should be present when any person was in there, regardless of the time. One staff member said, "It's to manage falls for people so we can keep an eye on them should they try and walk by themselves, as a lot of people were falling unwitnessed."
- Although this person had not had any recent falls, the system the provider told us they had put in place to keep people safe was not effective as people remained at risk of having unwitnessed falls.
- Another person was identified as being 'very high risk of falls'. When the person had fallen, the provider had taken some action to mitigate further risk. For example, they had received a review of their medicines and changes made, referrals and assessments had been completed by other professionals and equipment such as sensor alarms had been introduced.
- We checked records for this person and not all of the information recorded was up to date. For example, a 'physical assessment' and 'this is me' plan identified the person 'mobilised independently'. However, this did not match the moving and handling care plan that stated following an occupational therapist assessment in February 2019, the person now required a walking aid and one member of care staff to support them. Staff confirmed this was accurate and the person required one staff and a walking aid.
- During our inspection, we observed this person walking down the corridor independently using their walking aid. Shortly after, a staff member followed the person down the corridor and then walked alongside them. This meant the person was placed at an increased risk of falls as a member of staff was not present when they were mobilising, as required.
- Staff we spoke with raised concerns with how they managed the risk of falls within the home. A staff member said, "We know [person] should be supervised when they mobilise. If they stand in their room the alarm goes off and we can respond. However, if they are anywhere else we don't see it. The person isn't one to one so they sometimes get up and we don't know if we are with someone else." This was the person who we observed independently walking down the corridor.
- Since our last inspection, the provider had introduced a more robust system to ensure action was taken

when incidents and accidents occurred within the home. For example, when a person had fallen, we saw their dependency rating was reviewed, falls risk assessments were updated and care plan evaluations were completed.

● After our inspection we received further reassurance from the provider they had taken further action following our inspection and feedback. This included further changes to the management of communal areas.

Staffing and recruitment

● Staff we spoke with raised concerns about staffing levels in the home. They told us the introduction of the member of staff in the communal lounge on the ground floor had impacted on staffing levels. One staff member said, "There are three staff down stairs. Three people need two staff to support them. If one of us is in the lounge and the other two are with someone, there are no staff downstairs to respond to call bells." Another staff member said, "There are definitely not enough staff, no."

● Although the provider had recently reviewed and increased staffing levels for the night shift, the management team confirmed they had not reviewed staffing levels for day shifts since the introduction of the monitoring of the lounge. They told us they had introduced the staff member in the lounge with the consultation of the staff.

● We saw staff were available for people. However we observed communal lounges on both the ground and first floor were unsupervised at times, when people at risks of falls were present.

Learning lessons when things go wrong

●Follow the safeguarding incident that had occurred within the home, we saw the provider was introducing more robust systems so that when incidents occurred these were investigated and actions put in place to ensure learning could be considered when things went wrong.

Using medicines safely

● Medicines were managed in a safe way. We saw staff administering medicines to people and they stayed with them ensuring they had taken them. One person said, "They are good with my tablets."

● We saw there were effective systems in place to store, administer and record medicines to ensure people were protected from the risks associated to them.

Systems and processes to safeguard people from the risk of abuse

● There were procedures in place to ensure people were protected from potential harm. We saw when needed concerns had been raised appropriately by the provider and in line with these procedures to ensure people were protected.

● Staff knew how to recognise and report potential abuse. One member of staff told us, "It is protecting people from any kind of abuse or harm." Another staff member said, "I would report my concerns to the manager, there are telephone numbers in the office that we can report concerns externally if we need to."

Preventing and controlling infection

● There were infection control procedures in place and these were followed. The environment was clean, maintained and free from infection.

● We saw staff used personal protective equipment such as gloves and aprons when needed. Staff confirmed this was available to them.

● The provider completed an audit in relation to infection control, the last audit identified compliance in this area.

Requires Improvement

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

Service management and leadership was inconsistent.

Continuous learning and improving care

- Before our inspection, we received information from the local authority that a safeguarding concern had been substantiated within the home. This incident had occurred in August 2018. When we were alerted to this situation, we liaised with the previous registered manager regarding this. In March 2019 we contacted the provider for further information. They informed us they were not aware of this incident occurring and the substantiated safeguarding. This meant the systems the provider had in place for managing safeguarding concerns and sharing information were not effective.
- Since we notified the provider, they have introduced a more robust system to ensure safeguarding concerns are monitored and the outcomes shared.
- Following the outcome from the safeguarding, the local authority recommended the care home carry out some actions. Before the inspection, we asked the provider for an update on the actions which they provided to us and we checked as part of the inspection.
- Although we saw some of the actions had been completed, we found some actions the provider told us they had taken had not yet been implemented. For example, the provider told us a risk assessments now contained 'a Red/Amber/Green (RAG) scoring system for high/medium/low risk.' We saw and the management team confirmed this had not yet been introduced. The provider also told us 'Staff are trained to score risk assessments accurately', however the management team confirmed that staff had not received the training in this area yet, although it was planned.
- We saw a more robust system had been introduced for reporting accidents in the home. The provider analysed the information to identify trends and patterns that were now occurring within the home.
- Other quality checks were completed within the home. These included monitoring of medicines and an infection control audit.
- We saw when areas of improvement had been identified the necessary action had been taken. For example, when medicine had been opened and not dated, a weekly spot check had been introduced to ensure this was continually monitored and reviewed.

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

- The provider sought the opinions of people who lived in the home and their relatives. This was through meetings and satisfaction surveys.
- People and relatives had the opportunity to attend meetings to discuss and share any concerns.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- People, relatives and staff spoke positively about the management team and the support they received.

● One person said, "The staff are all great." A relative commented, "I have no concerns with anything here."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.
● Staff felt supported by the new managers. They had the opportunity to raise concerns by attending team meetings and individual supervisions.
● All staff understood their roles and responsibilities and there were clear lines of delegation.
● The provider ensured that we received notifications about important events so that we could check that appropriate action had been taken.
● The rating from the previous inspection was displayed in the home in line with our requirements.

Working in partnership with others
● There were good relationships with local health and social care professionals.