Majestic Care Home Limited

Waterside Care Home

Inspection report

192 Queens Promenade
Bispham
Blackpool
Lancashire
FY2 9JS

Tel: 01253351612
Website: www.watersidecarehome.co.uk

Date of inspection visit:
07 March 2017

Date of publication:
28 April 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 01 December 2015.

Since that inspection we have been informed about a specific incident which raised concerns in relation to safeguarding procedures, care planning arrangements, medicines management and management of behaviour that challenged. As a result we undertook a focused inspection to ensure fundamental standards were in place to keep people safe. This report only covers our findings in relation to the raised concerns. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Waterside Care Home on our website at www.cqc.org.uk"

Waterside Care Home is registered to provide personal care for a maximum of 19 older people. The home is situated on the promenade at Bispham. The accommodation comprises of 19 single bedrooms, of which 14 have en-suite facilities. A stair lift enables people to gain access between the ground and first floor. When we completed this focussed inspection there were 19 people who lived at the home.

The service did not have a registered manager in place. 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.

Prior to this inspection the manager had submitted an application to be registered with the Care Quality Commission (CQC). This was being dealt with by CQC's registration team when the inspection visit took place.

We asked the regional manager and the home's manager if there had been any safeguarding incidents involving people who lived at the home since we last inspected the service. They told us there had been one which had been investigated by the local authority safeguarding team. The manager said there hadn't been any incidents which she had needed to report.

Staff spoken with told us they had received safeguarding training and understood their responsibility to report concerns to the manager.

We noted within the daily notes there had been incidents where people had been aggressive towards members of staff. There had been no incident reports completed identifying the results of challenging behaviour by people who lived at the home towards staff. The manager acknowledged documentation was poor and confirmed these would be reviewed.

We found care records did not always provide staff with clear guidance to meet people's needs.
Care plans did not provide clear strategies for staff supporting people who became agitated and distressed.

This was breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment).

The staff members we spoke with told us there were people who could be challenging but they hadn't received any training to manage their behaviour.

This was breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing).

We observed staff providing support to people throughout our inspection visit. We saw they were kind and patient and showed affection towards the people in their care. The atmosphere in the home was relaxed and calm and we saw no evidence of behaviour that challenged the service during our inspection visit.

We spoke with a visiting healthcare professional during our inspection visit. They told us they were happy with the care provided at the home and had no concerns about the staff who worked there. They told us they had never seen anything that would need to be reported the local authority safeguarding team.

We found medication procedures at the home were safe. Medicines were safely kept with appropriate arrangements for storing in place. Staff responsible for the administration of medicines had received training to ensure they had the competency and skills required.

The service had not maintained accurate, complete and contemporaneous records in respect of each person who lived at the home. We found care records did not provide staff with clear guidance to meet people's needs. There had been no incident reports completed following incidents where people who lived at the home had presented behaviour which challenged staff. We found incomplete records including consent forms, care needs and dependency forms which hadn't been signed or dated.

The provider did not have effective quality assurance systems in place to identify where quality and safety was compromised. Systems were not in place to safeguard all people against risk and ensure appropriate care was delivered to meet individual needs.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance).

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

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.

Staff had not received training to meet the specific needs of people who presented with behaviour that challenged and this placed them at risk of harm.

Strategies were not in place to manage behaviour that challenged the service.

Incident reports had not been completed following aggressive behaviour by people who lived at the home towards staff.

People were protected against the risks associated with unsafe use and management of medicines. This was because medicines were managed safely.

Is the service well-led?

Requires Improvement

Service was not well led

The service had not maintained accurate, complete and contemporaneous records in respect of each person who lived at the home.

The provider did not have effective quality assurance systems in place to identify where quality and safety was compromised.

Waterside Care Home

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 checked 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.

We undertook an unannounced focused inspection of Waterside Care Home on 07 March 2017. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well-led?

The inspection was prompted in part by notification of an incident involving a person who had previously lived at the home. This incident is subject to a specific investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of unsafe medicines management, safeguarding procedures, care planning and management of behaviour that challenged at Waterside Care Home.

The inspection was undertaken by two adult social care inspectors and a specialist advisor. The specialist advisor was a qualified pharmacist and looked at the services medicines procedures. During our inspection we spoke with two people who people who lived at the home, a visiting healthcare professional, the regional manager, the home's manager and three staff members. Prior to our inspection visit we contacted the commissioning department at the local authority who shared with us information they held about the home. This helped us to gain a balanced overview of what people experienced accessing the service.

We looked at care records of seven people, arrangements for staff training on behaviour that challenged the service and safeguarding people. We also assessed the services medicines procedures.

Inadequate

Is the service safe?

Our findings

We observed staff providing support to people throughout our inspection visit. We saw they were kind and patient and showed affection towards the people in their care. The atmosphere in the home was relaxed and calm and we saw no evidence of behaviour that challenged the service during our inspection visit.

We asked the regional manager and home manager if there had been any safeguarding incidents involving people who lived at the home since we last inspected the service. They told us there had been one which had been investigated by the local authority safeguarding team. The manager said there hadn't been any incidents of abuse or poor care which she had needed to report. Staff spoken with and care records seen confirmed there had been no unreported safeguarding incidents at the home.

When reviewing care records for people who had behaviour that challenged the service we noted within the daily notes there had been incidents where people had been aggressive towards members of staff. Three staff members we spoke with confirmed such incidents had happened. We saw there were no incident reports completed. We spoke with the manager to ascertain if these incidents had been reported to them in order that they could assess people were safeguarded and their needs are met. The manager told us she was unaware of the incidents and confirmed there had been no incident reports completed.

The staff we spoke with told us there was no guidance or strategies within care plans to inform them how to manage people's behaviour when they presented with challenging behaviour. One staff member told us, "We know which residents can become agitated and have learnt how to deal with them. I am comfortable with this and confident I can calm people down."

This was breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment). The provider had failed to adequately assess the risks to the health and safety of people who lived at the home and failed to do all that is reasonably practicable to mitigate any such risks.

We discussed training with the three staff members. They all confirmed they had received dementia training and this had covered recognising triggers for challenging behaviour. However they told us the training hadn't covered what you do if a challenging situation occurred. Training in managing challenging behaviour, appropriate restraint and de-escalating situations is important for staff who work with people whose behaviour may challenge. Staff need to be able to identify the causes of challenging behaviour and understand there is a range of non-aversive interventions and where and when to use them. This will enable them to reduce the possible risk of harm to themselves and people supported by the service.

We checked training records which confirmed staff did not have training for managing behaviour that challenged. We spoke with the regional manager for the service who confirmed staff had not received this training. They told us they were in the process of sourcing appropriate training.

This was breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014 (Staffing). The provider had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed to meet people's needs.

We spoke with a visiting healthcare professional during our inspection visit. They told us they were happy with the care provided at the home and had no concerns about the staff who worked there. They told us people who lived at the home looked well when they visited and they seemed to get on well with staff. The healthcare professional told us they had never seen evidence of poor care or anything that caused them concern during their visits to the home.

We looked at how medicines were prepared and administered. Medicines had been ordered appropriately, checked on receipt into the home, given as prescribed and stored and disposed of correctly. There were no expired medicines found and all medicines were organised and stored neatly.

The drugs trolley where medicines were stored was locked and secured to the wall in the living area. Controlled drugs were stored in a controlled drugs cabinet. These were inspected and no analomies in records were found. We looked at 19 Medication Administration Records (MAR) and found they were complete, legible and accurate. A medication audit had recently been completed by a pharmacist on behalf of the local authority. Recommendations from the audit were being actioned when we undertook our inspection visit.

We observed medicines being administered at lunch time by a senior carer. We saw one person was offered a liquid medicine in a purple orange syringe as advised by National Patient Safety Agency directive on dosing of oral medicines. The person had recently been discharged from hospital and was on a reducing dosage of their medicine. We saw a second person offered their medicines by the senior carer. We noted the senior carer patiently waited for the person to take their medicines themselves. The medicines cabinet was locked securely whilst attending to each person and medicines were signed for after they had been administered.

The key to the medication locker and cupboards were in the possession of the senior carer and these were handed over after each shift. We saw documentation for the transfer of keys had been completed.

People had access to homely medicines and were able to self-medicate their inhalers. We saw where this had been agreed self-medication assessments had been completed.

Requires Improvement

Is the service well-led?

Our findings

We found care records did not provide staff with clear guidance to meet people's needs. The care record of one person had documented they displayed random episodes of behaviour that challenged, could be agitated and unpredictable. There was no information about how staff should support the person should this behaviour present itself. There were no clear strategies for staff supporting people who became agitated and distressed. We saw entries on two people's daily notes recording they had hit staff members assisting them with their care. There had been no incident reports completed and the manager told us she was unaware of the incidents. We found incomplete records including consent forms, care needs and dependency forms which hadn't been signed or dated. We spoke with the regional and home manager who accepted improvements were required to their record keeping.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance). The service had not maintained accurate, complete and contemporaneous records in respect of each person who lived at the home.

This inspection was undertaken because we received concerns in relation to the services medication and safeguarding procedures, care planning arrangements and management of behaviour that challenged. At this inspection we found management of medicines were safe. However we identified breaches of Regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have effective quality assurance systems in place to identify where quality and safety was compromised. Systems were not in place to safeguard all people against risk and ensure appropriate care was delivered to meet individual needs. We spoke with the regional and home manager who accepted improvements were required to their quality assurance systems.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to adequately assess the risks to the health and safety of people who lived at the home and failed to do all that is reasonably practicable to mitigate any such risks.

The enforcement action we took:

Imposed conditions in relation to management of challenging behaviour, assessment of risk to people's safety and poor governance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had not maintained accurate, complete and contemporaneous records in respect of each person who lived at the home.

The enforcement action we took:

Imposed condition in relation to poor governance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed to meet people's needs.

The enforcement action we took:

Imposed condition in relation to staff training for managing behaviour that challenged.