Vivacare Limited

Waterloo House

Inspection report

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Date of inspection visit:
06 March 2018

Date of publication:
27 April 2018

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?	Requires Improvement

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on 06 March 2018.

Waterloo House is a 'care home'. 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.

The care home provides accommodation and personal care for up to 20 people who have mental health needs. On the day of the inspection 14 people were living at the service. The provider also operates another mental health care home in Cornwall.

We carried out a previous comprehensive inspection on 21 and 22 June 2017. The service was rated requires improvement, but remained in special measures. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe.
We told the provider to make improvements to ensure people's medicines were managed safely, and that infection control practices were implemented to help reduce the unnecessary spread of infection. We also told the provider to ensure staff received training so that they could meet people's needs effectively, and that people's human rights were protected. In addition, we asked the provider to improve the leadership of the service, update policies and procedures and implement an effective monitoring process to help identify when improvements were required. In line with our enforcement policy we took action to impose a positive condition on the provider's registration, which meant on a monthly basis they were required to send us an action plan relating to infection control procedures, care plans and risk assessments.

During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures, but further improvements regarding the provider's monitoring systems are still required.

Since our last inspection, the previous manager had left, and a new manager had been employed and had had submitted their application to the Commission to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered person's'. 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's medicines were now managed safely. People were now protected from good infection control practices. Staff had received training in infection control, and put their knowledge into practice.

People told us they felt safe. People were protected from abuse because staff knew what action to take if they suspected someone was being abuse, mistreated or neglected.

Overall, people lived in an environment which was safe. The shed in the garden now had a padlock, and items which could pose a risk within the service were locked away. However, water temperatures in three bathrooms were found to be very hot. The manager explained a new maintenance person had been employed, and one of their roles would be to ensure water temperatures are at the correct temperatures. A new monitoring system was also being put into place to help ensure the ongoing safety of the environment.

People were encouraged to take risks. Risk assessments were in place to help support risk taking, and help reduce risks from occurring. People who had behaviour that may challenge staff or others had risk assessments in place which gave good guidance and direction to staff about how to support the person, whilst taking account of everyone's safety.

People had their needs met by suitable numbers of staff. Staff responded promptly to people when they needed support, and had time to sit and spend with them socially. Staff, were recruited safely, and checks carried out with the disclosure and barring service (DBS) ensured they were suitable to work with vulnerable adults.

People's human rights were now protected. Best interests meetings had been carried out in line with the Mental Capacity Act 2005 (MCA) when restrictive practices were in place, records showed that staff, were supporting people to work towards independence and recovery. People's consent to care was documented, and staff respected people's wishes when they chose not to do something, such as take their prescribed medicines.

People were now supported by staff who had received training to meet their needs effectively. Staff meetings, one to one supervision of staffs practice and appraisals of performance, were being undertaken with staff telling us they felt "supported".

People's health and social care needs were holistically assessed. The provider worked closely with external health and social care professionals, to help ensure a coordinate approach to people's care.

People's communication needs were known by staff. Staff had received training in how to support people with different communication needs. The provider had taken account of the Accessible Information Standard (AIS). The AIS is a requirement to help make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.

People enjoyed the meals, and people's individual preferences were catered for. People had independent access to cold and hot drinks, and had care plans in place to support their nutrition.

People lived in an environment which was adapted to their needs. A decoration programme for the service was in place, and people were being part of decisions about colour schemes.

People were supported by kind staff. Staff all spoke of their love and passion for their job, and for the people living at the service, describing it like "a family".

People were given emotional support when distressed and were involved in making decisions about their own care. People had access to independent advocacy services, and were supported to access these when required.

Overall, people's individual equality and diversity preferences were known and respected. Some people had care plans in place detailing their religious and cultural needs, with one person telling us "If I want to go to church I ask the staff and they make sure I can go".

People's privacy and dignity was promoted and their independence was encouraged. People's bedrooms were personalised, and people's family and friends were welcomed warmly by staff. Special occasions such as birthdays were celebrated.

People received personalised care and support. People received a pre-assessment of their care prior to moving into the service. People's pre-assessment was then used to form the basis of their individualised care plan, providing staff with information about how to meet people's needs in the way they wanted and needed their needs to be met. Care plans were based on people's health and social care needs, and supported their ongoing mental health recovery.

People's care plans were reviewed to help ensure they were reflective of people's current care needs. People, if they wanted to be, were part of the review and care plans detailed when people had been involvement in making amendments.

People had the opportunity to engage in social activities, however whilst no one complained about the availability of social activities, social activities were not structured each day, which meant people may not always feel motivated or have something to look forward to. The manager positively listened to our feedback, and told us they would address this by speaking with people to obtain their views.

People's end of life wishes had been discussed and had been detailed in people's care plans. When people had not wanted to talk about their end of life wishes, this had been respected and recorded.

The new manager and provider had devised some new systems and processes to help monitor the ongoing safety and quality of the service, and further audits were being devised and implemented.

The provider visited the service on a monthly basis, to meet people, staff and to discuss the day to day management of the service with the manager. Whilst this provided some assurances about the ongoing quality and safety of the service, the provider was not specifically checking the work of the manager. Therefore, the provider themselves had recognised that these visits needed to be more robust, so told us they would be appointing a person to carry out a monthly visit of the service.

People lived in an environment which was positive and inclusive. During our inspection, the manager and staff team displayed through their interactions the provider's mission statement of "A client is the most important person in our care home. They are not an interruption to our work, they are the purpose to it. They are not an outside in our home, they are part of it, as it is their home. We are not doing them a favour by serving them, they are doing us a favour by allowing us the opportunity to do so".

The new manager did not have experience of mental health but had access to mental health advice from the manager of the providers other care home. To strengthen the mental health expertise within the service, the provider told us they would be recruiting a deputy manager with mental health experience. The local authority service improvement team, told us they felt mental health leadership was lacking.

People lived in a service whereby the provider learned from their mistakes in order to help improve the service. People, staff and the public were involved in the ongoing development of the service. People's comments and complaints were respectfully listened to, and used to help improve the service.

People lived in a service whereby there was continuous learning taking place, to help facilitate improvement and ensure sustainability. The improvements found at this inspection, demonstrated that the provider worked in partnership with external agencies in an open and transparent way, for the benefit of people. Throughout our inspection, the registered manager was honest about what they had identified themselves as needing improvement. This open and transparent approach demonstrated the providers understanding and recognition of the Duty of Candour. The Duty of Candour means that a service must act in an open and transparent way in relation to care and treatment provided when things go wrong. The provider had displayed their latest rating in line with legislation.

The Commission had been informed of significant events which had occurred in line with their legal obligations. For example, safeguarding alerts or approved Deprivation of Liberty (DoLS) applications.

We found a breach of our regulations during this inspection. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was now safe.

People's medicines were now managed safely.

People were now protected from good infection control practices.

People were protected from abuse.

People's risks associated with their care were managed safely so they could be supported to stay safe, but still have their freedom respected.

People had their needs met by suitable numbers of staff who were recruited safely.

People lived in a service whereby the provider learned from their mistakes in order to help improve the service.

Is the service effective?

Good

The service was now effective.

People's consent and human rights were now protected in line with the mental capacity act.

People were supported by staff who had received training to meet their needs effectively.

People's health and social care needs were holistically assessed.

People's communication needs were known by staff.

People enjoyed the meals, and people's individual preferences were catered for.

People were involved in decisions about the environment.

Is the service caring?

Good

The service remained caring.

People told us staff, were kind and respectful.

People were involved in making decisions about their own care. People's individual equality and diversity preferences were known and respected.

People's privacy, dignity and independence were promoted.

Is the service responsive?

Good

The service remained responsive.

People received personalised care and support.

People had opportunities to participate in social engagement

People's complaints were listened to positively, and used to help improve the service.

People's end of life wishes had been discussed.

Is the service well-led?

Requires Improvement

Aspects of the service were still not well-led.

The new manager and provider had devised some new systems and processes to help monitor the ongoing safety and quality of the service. However, these had not always been robust in identifying areas requiring improvement.

People lived in an environment which was positive and inclusive.

People, staff and the public were involved in the ongoing development of the service.

People lived in a service whereby there was continuous learning taking place to help facilitate improvement and ensure sustainability.

The provider worked in partnership with external agencies in an open and transparent way, for the benefit of people.

Waterloo 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.

The inspection took place on 06 March 2018 and was unannounced and undertaken by one inspector, a mental health specialist advisor 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.

Before our inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the provider had sent us since the last inspection. A notification is information about important events, which the service is required to send us by law. We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also contacted Healthwatch Plymouth and the local authority quality and service improvement team to ask if they had any feedback about the service. Where feedback was provided, it can be found through-out the inspection report.

During our inspection, we spoke and met with 13 people living at the service, one relative, six members of care staff, and the new manager.

We observed care and support in shared areas. We spoke with people in private and pathway tracked three people. This is a process by which we follow a person's care experience through the service, to ensure their needs and preferences are being met in line with their care plan. We assessed the environment for safety and looked at training records. We also looked at medicine administration records, policy and procedures and the provider's quality assurance checks.

Good

Is the service safe?

Our findings

At our last inspection on 21 and 22 June 2017 we rated this key question as requires improvement, because people's medicines were not being safely managed, and infection control practices were not implemented to help reduce the unnecessary spread of infection. During this inspection we looked to see if improvements had been made, and found action had been taken.

People's medicines were now managed safely. A new medicine room had been created which meant staff had more space to administer medicines. Medicines were stored securely, and a review of four medicines showed stock matched people's records. People's medicine administration records (MARs) were signed when medicines were given, but medicines which had been hand written on MARs for March, had not been double signed for accuracy. Practice which is not in line with guidelines set out by the National Institute of Clinical Excellence (NICE). The manager took immediate action to rectify this.

New medicine protocols had been put into place for medicines relating to mental health. Records now demonstrated when people should receive these medicines and the involvement of other external healthcare professionals in their administration. People told us, "I take medication for my schizophrenia…at regular times, the staff, give it to me" and, "I know what they are for and the staff gives it to me at certain times".

People prescribed medicines to be taken when required (PRN), such as paracetamol, now had records in place to provide information to guide staff in their administration. Such as what the medicines were for, symptoms to look for, the gap needed between doses or the maximum dose. Medicines which were required to be kept in the fridge were stored at the correct temperature, with accurate temperature records kept. People who required pain relief patch medicines to be applied to their body, now had guidance in place about where the patches should be positioned. This helped to ensure they were being applied in line with prescribing guidelines.

People who chose to administer their own medicines now had risk assessments in place to help reduce any associated risks. The manager told us she wanted to continue to develop these with people. The provider told us in their provider information return (PIR) that, "We involve people in the administration of their medication and in medication reviews if at all possible, and act swiftly on medication changes as a result of visits to the GP".

There was now a medicine policy in place to support staffs practice. The policy reflected best practice, and had been written in line with National Institute for Clinical Excellence (NICE) guidelines. Staff had received medicines training, and an assessment of their ongoing skills and competency was now being carried out. New monitoring practices had been put into place to help identify when improvements were required. The audit for this month had yet to be carried out, so would not have identified the hand written MARs.

People were now protected from good infection control practices. Staff had received training in infection control, and put their knowledge into practice. Soiled laundry was now being washed safely and procedures

for handling clinical waste were now more robust. A new infection control policy had been devised and infection control audits were carried out to help identify where improvements were required. Staff wore personal protective equipment (PPE) when appropriate, for example when entering the kitchen.

People told us they felt safe commenting, "Yes I feel safe here" and, "Yes I do". People were protected from abuse because staff knew what action to take if they suspected someone was being abuse, mistreated or neglected. Staff were confident the manager would take action, but also knew where to access the contact details for the local authority safeguarding team should they have to make an alert in the managers absence.

Overall, people lived in an environment which was safe. The shed in the garden now had a padlock, and items which could pose a risk within the service were locked away. Fire checks were carried out and people had personal emergency evacuations plans (PEEPs) in place. PEEPs help to provide information to emergency service about how people should be supported in an emergency. However, water temperatures in three bathrooms were found to be very hot. The manager explained a new maintenance person had been employed, and one of their roles would be to ensure water temperatures are at the correct temperatures. In the meantime, a risk assessment would be carried out, to help determine if people were at risk of burning themselves. Although we were told no one was at risk, there were also no environmental risk assessments in place in respect of the open access of the laundry. The manager told us they would take action to implement these immediately. A new monitoring system was being put into place to help ensure the ongoing safety of the environment, which when implemented, would highlight these areas.

People were encouraged to take control of their care which included taking risks. Risk assessments were in place to help support risk taking, and reduce risks from occurring. For example, two people liked to make their own hot drinks and meals in the kitchen, and one person liked to do their own laundry. People who had behaviour that may challenge staff or others had risk assessments in place which gave good guidance and direction to staff about how to support the person, whilst taking account of everyone's safety.

People had their needs met by suitable numbers of staff, commenting "There are two, sometimes three staff members at night. They are enough for me" and, "There are enough staff, very good staff". Staff responded promptly to people when they needed support, and had time to sit and spend with them socially. Whilst there was no staffing tool used to help determine staffing levels, the manager explained they knew people's needs well and adapted staffing accordingly. The manager told us additional staff were on duty during the week to support people could go to health and social care appointments. Staff, were recruited safely, and the required checks carried out such as with the disclosure and barring service (DBS). This ensured they were suitable to work with vulnerable adults.

People lived in a service whereby the provider learned from their mistakes in order to help improve the service. For example, a medicine error had arisen in respect of a person's insulin, so additional training had been arranged for staff.

Good

Is the service effective?

Our findings

At our last inspection on 21 and 22 June 2017 we rated this key question as requires improvement, because staff had not received training to be able to meet people's needs effectively, and people's human rights were not being protected. During this inspection we looked to see if improvements had been made, and found action had been taken.

People's human rights were now protected. We checked whether the service was working within the principles of the Mental Capacity Act (MCA) 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met. 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 Act 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found the manager and staff now had a good understanding of the legislative framework because they had undertaken training. People were assessed in line with the MCA to check their ability to consent to their own care and treatment. DoLS applications had been made and approved, and staff were knowledgeable of why people had a DoLS application in place, and what the restrictions were. The provider told us within their provider information return (PIR), that "Weekly meetings are held with staff to allow the manager to raise issues with regard to capacity…and with the adult safeguarding team, where appropriate". People's consent to care was documented, and staff respected people's wishes when they chose not to do something, such as take their prescribed medicines.

Best interests meetings had been carried out when restrictive practices were in place, records showed that staff were supporting people to work towards independence and recovery. For example, people who were subject to mental health orders in line with the Mental Health Act 1983, were seen to have had their 'day leave' reviewed and increased, to promote independence and autonomy.

People were now supported by staff who had received training to meet their needs effectively. The manager had ensured staff undertook training the provider had deemed as 'mandatory'. Some of which included, moving and handling, health and safety, mental health, first aid and fire safety. Training specific to people's needs was also completed, such as challenging behaviour, activity planning, stoma care, learning disability and autism. Staff, were complimentary of the recent diabetes training, sharing with us what they had learnt and what they had put into practice as a consequence. There was a training record, so the provider could easily see what training staff had completed and what was still outstanding. Staff meetings, one to one supervision of staff practice and appraisals of performance, were being undertaken with staff telling us they felt "supported".

People's health and social care needs were holistically assessed. The provider worked closely with external health and social care professionals, to help ensure a coordinate approach to people's care. People's care plans detailed a going review of their mental and physical health with care co-ordinators, community mental health team, social workers, nurse specialists, psychiatrist as well as GP's. People commented, "If I need to see the GP the staff organise an appointment for me", and "I have got diabetes and I see the GP regularly".

People had a hospital transfer document within their care plan, which meant in the event of a hospital admission, external healthcare professionals would know what people's needs were and how to meet them. This helped to ensure continued effective care and support.

People's communication needs were known by staff. Staff had received training in how to support people with different communication needs, and whilst there was no one living at the service that required individualised support; one member of staff told us how they had previously supported one person who had been blind. Explaining how they had assisted with them with their nutrition, and read the newspaper out loud. People's care plans were being redevised to make them less cumbersome and more user friendly for people. Pictorial images were displayed on the menu and activities board to help ensure it was in a suitable format for everyone. This demonstrated the provider had taken account of the Accessible Information Standard (AIS). The AIS is a requirement to help make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.

People enjoyed the meals, and people's individual preferences were catered for. On the day of our inspection, three different types of lasagne were being made, with one person commenting "I don't eat meat so the cook made a special lasagne with mushrooms for me today". Other comments included, "There are two chefs, one working for two days, the other for five. They offer a good choice of meals", and "There are two food choices and the food is delicious". People also enjoyed take-a-ways at the weekend. If people had their own spiritual or cultural wishes relating to their diet, we were told this would be catered for.

People had independent access to cold and hot drinks, and had care plans in place to support their nutrition. People who were at risk of not eating and drinking enough had this monitored and staff were knowledgeable about what actions to take. For example, fortifying meals and implementing food and fluid charts to record the person's daily intake. External support would then be requested if concerns continued.

People lived in an environment which was adapted to their needs. Specialist equipment in bathrooms, meant people were able to get up from the toilet more easily. People could access the upper floors by lift or stairs. For people who wanted to keep fit, a chair had been placed half way up the stairs to enable people to attempt the stairs in stages. People were involved in decisions about the environment. For example, at a recent house meeting, people had told the provider they wanted a modern TV and new sofas and chairs for the lounge. So these had been ordered. A decoration programme for the service was in place, and people were being part of decisions about colour schemes.

Good

Is the service caring?

Our findings

The service remained caring.

People were supported by kind staff, with one person telling us "The staff are very caring". There was a relaxed and fun atmosphere within the service. Staff all spoke of their love and passion for their job, and for the people living at the service, describing it like "a family". People also described this ethos, commenting "The whole place is like one big family and I am just one of the family. They are very kind".

People living at the service showed care and concern for each other. For example, we were told when one person had returned from hospital, they had been greeted warmly at the front door by everyone and welcomed home.

Staff took time to support people to look their best. One member of staff brushed one person's hair and put it in a hair style for them. The member of staff displayed a very kind and caring approach whilst doing it.

People were given emotional support when distressed. For example, the manager offered reassurance to a distressed person, by giving them a cup of tea and by having a chat. The person responded well to the manager's intervention.

People were involved in making decisions about their own care, commenting "They ask me questions on what I want to do, when to take my medications, how to manage my diabetes, and my weight", and "We talk about what I would like to do". People had access to independent advocacy services, and were supported to access these when required.

Overall, people's individual equality and diversity preferences were known and respected. Some people had care plans in place detailing their religious and cultural needs, with one person telling us, "If I want to go to church I ask the staff and they make sure I can go". The provider's, provider information (PIR) stated, "Specific care plans are in place to ensure people sexuality and sexual orientation are taken into consideration when delivering care. Care plans and social activities are included for residents to engage with the local Christian community. Dietary considerations are given to those who may not eat a certain diet as per their faith. People are given the freedom to express their faith in whatever way is suitable to them, they are given the opportunity and support to opt out of mainstream Christian festivity such as Christmas or Easter".

People's privacy and dignity was promoted, with one person commenting, "They treat me with dignity and respect my privacy". Staff told us how they promoted people's dignity by closing doors when providing personal care, and by reminding people to cover up their bodies when they came out of the shower.

People's independence was encouraged, by completing household tasks such as laying tables, preparing their own meals or washing their own laundry. Staff positively recognised people's contributions and empowered them. For example, during an activity one person was not able to stand properly, so a staff

member offered the person a chair and helped the person to write down the words on the board so they could still participate and join in.

People's bedrooms were personalised, and people's family and friends were welcomed warmly by staff. Special occasions such as birthdays were celebrated by having a buffet and birthday cake.

Good

Is the service responsive?

Our findings

The service remained responsive.

People received personalised care and support. People were assessed prior to moving into the service. The pre-assessment outlined people's medical history and was holistic in reflecting people's individual needs based on their mental health diagnosis, previous treatments and medicines that have worked well. It also incorporated information about multi-disciplinary teams and specialists involved in people's care, to help ensure a continued and consistent approach to their care. For example, one person's pre-assessment detailed that it was essential that aspects of their health was monitored to help prevent further deterioration from occurring. The providers, provider information return (PIR) stated, "One of our key aims is to meet the current and future needs of people who use our service. We can only do this if we firstly ascertain what those needs are. We then need to design and deliver services that meet these needs in the way that people prefer".

People's pre-assessment was then used to form the basis of their individualised care plan, providing staff with information about how to meet people's needs in the way they wanted and needed their needs to be met. Care plans were based on people's health and social care needs and supported their ongoing mental health recovery. For example, one person's care plan detailed they had agreed to have their money monitored, because previous addictions had led to over spending and debt. Another person's care plan detailed how they had been supported to manage aspects of their life that they found particularly difficult/challenging.

People's care plans were reviewed to help ensure they were reflective of people's current care needs. People, if they wanted to be, were part of the review and care plans detailed when people had been involvement in making amendments. For example, one person had spoken with staff about their wish to improve their health. So their care plan had been adjusted to help ensure this occurred. Another person told staff they wanted to try and wash their own clothes, but did not know how to use a washing machine. So a care plan had been created to help support the person to achieve this.

People had the opportunity to engage in social activities, for therapeutic purposes. On the day of our inspection some people participated in a quiz and went out on a trip. Whilst no one complained about the availability of social activities, social activities were not structured each day, which meant people may not always feel motivated or have something to look forward to. The manager positively listened to our feedback and, told us they would address this by speaking with people to obtain their views.

People's end of life wishes had been discussed and had been detailed in people's care plans. All necessary paper work was in place and signed by the person and/or their next of kin. This included a Treatment Escalation Plan (TEP) and Do Not Attempt Resuscitation (DNAR). When people had not wanted to talk about their end of life wishes, this had been respected and recorded.

People's comments and complaints were respectfully listened to, and used to help improve the service. One person told us, "We have meetings once a month. We meet with the boss and make decisions together".

These meetings helped to reduce the occurrence of complaints or concerns. Other comments included, "There is a complaint book at the entrance" and "I would talk to one of the staff or the manager". The providers, provider information return (PIR) stated, "We seek feedback from people who use our service. We have a complaints procedure, anonymous where appropriate". The provider's complaints policy was given to people when they moved into the service, and was displayed within the service. However, the policy may not have been in a suitable format for everyone to understand. The manager told us, they would take action to review this to ensure it was in line with the Accessible Information Standard (AIS). The AIS is a requirement to help make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 21 and 22 June 2017 we rated this key question as Inadequate, because there was no effective leadership of the service, policies and procedures were not always in place, and there was no effective monitoring process to help identify when improvements were required. In addition, in line with our enforcement policy we took action to impose a positive condition on the provider's registration, which meant on a monthly basis they were required to send us an action plan relating to infection control procedures, care plans and risk assessments. During this inspection we looked to see if improvements had been made. We found most action had been taken, but the provider's monitoring systems still required improving.

The Commission had been reviewing the provider's monthly action plan, and had been satisfied with the content and progress being made. The new manager and provider had devised some new systems and processes to help monitor the ongoing safety and quality of the service. These included care plan, medicines and infection control audits. Further audits were being devised and implemented to help monitor other aspects of the service, such as health and safety and accidents and incidents.

Since our last inspection, the previous manager had left, and a new manager had been employed and had had submitted their application to the Commission to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered person's'. 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.

The provider visited the service on a monthly basis, to meet people, staff and to discuss the day to day management of the service with the manager. Whilst this provided some assurances about the ongoing quality and safety of the service. The provider did not complete their own formal checks to help identify were improvements were required. This meant the provider was not specifically checking the work of the manager such as, reviewing people's care plans, or the management of people's medicines. They had also failed to identify the water through-out the home was not being thermostatically controlled, to prevent people from scalding themselves. The provider themselves had recognised these visits needed to be more robust, so told us they would be appointing a person to carry out a monthly visit of the service. This person would be responsible for completing a service audit, which would create an action plan for ongoing improvement. The local authority service improvement team, who had visited in January 2018, had also requested improvements were made to the overall governance of the service.

The provider did not have a governance framework, to help monitor the management and ongoing quality and safety of the care people received. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Overall, people lived in a service whereby there was continuous learning taking place, to help facilitate improvement and ensure sustainability. The manager attended the local authority dignity in care forum,

using it to bring back ideas and initiatives to implement within the service. However, the manager was not linked into any mental health networks, to help ensure best practice was implemented and shared within the service.

People lived in an environment which was positive and inclusive. The provider's mission statement was, "A client is the most important person in our care home. They are not an interruption to our work, they are the purpose to it. They are not an outside in our home, they are part of it, as it is their home. We are not doing them a favour by serving them, they are doing us a favour by allowing us the opportunity to do so". During our inspection, the manager and staff team displayed through their interactions this philosophy of care. The provider's, provider information return (PIR) stated, "Our mission statement was developed with staff, people who use our service and their families and it is underpinned by a set of values which include: honesty, involvement, compassion, dignity, independence, respect, equality and safety". Again, this is what we found embedded within the culture of the service.

The provider's (PIR) stated, "Good service provision starts with good leadership. We have invested to recruit the right leaders from the registered manager to the team leaders in charge of all aspects of our service delivery". Therefore, a new manager had recently taken over the management of the service and was in the process of submitting their application to become registered with the Commission. They had previously been the deputy manager of the service, and had been promoted. The manager expressed that they felt supported by the provider, who was on the phone most days and visited once a month. The new manager did not have experience of mental health but had access to mental health advice from the manager of the provider's other care home. To strengthen the mental health expertise within the service, the provider told us they would be recruiting a deputy manager with mental health experience. The local authority service improvement team, told us they felt mental health leadership was lacking. The providers PIR also stated "A new and more visible line management structure will provide staff with constructive feedback and clear lines of accountability".

People, staff and the public were involved in the ongoing development of the service. A sign displayed in the home stated, "Waterloo House wants to make your home as comfortable and enjoyable as possible. If you have any ideas or suggestions about how things can improve then please let one of the staff team know, and we will feedback to you what we can do to change things, to make things better for you".

The provider had a whistleblowing policy, which supported staff to question poor practice. Staff confirmed they felt safe to raise any concerns and felt confident the management would act on their concerns appropriately.

The improvements found at this inspection, demonstrated the provider worked in partnership with external agencies in an open and transparent way, for the benefit of people. For example, the provider had listened to constructive feedback from the local authority about their monitoring systems, and was continuing to improve and develop their processes accordingly. Throughout our inspection, the registered manager was honest about what they had identified themselves as needing improvement. This open and transparent approach demonstrated the providers understanding and recognition of the Duty of Candour. The Duty of Candour means that a service must act in an open and transparent way in relation to care and treatment provided when things go wrong. The provider had displayed their latest rating in line with legislation.

The Commission had been informed of significant events which had occurred in line with their legal obligations. For example, safeguarding alerts or approved Deprivation of Liberty (DoLS) applications.

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 17 HSCA RA Regulations 2014 Good governance Good governance Regulation 17 (1) (2) (a) (b) (c) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have a governance framework, to help monitor the management and ongoing quality and safety of the care people received.