

Waypoints Care Group Limited

Waypoints Plymouth

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

This service has been 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. 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 are still required.

We carried out an unannounced comprehensive inspection on 27 and 28 February 2017 and the service was placed into 'special measures'.

We told the provider to make improvements to make sure people were kept safe from avoidable harm and abuse. Risks associated with people's care were to be recorded and known by staff so they could be cared for safely, and received care that met with their needs, wishes and preferences. People's medicines to be given as prescribed and for the environment to be free from offensive odours. In addition, we told the provider people should be treated with dignity, respect and have their privacy respected and their confidential information to be stored securely. Staff training to be embedded into practice, nursing competency improved and the culture of the service reviewed to ensure people living with dementia received personalised care. We also requested the overall management, leadership and culture of the service should be improved. That the provider learnt from mistakes and implemented recommendations from the local authority safeguarding team, to help keep people safe. Also, the provider's monitoring processes, used to help identify when improvements were required, were inadequate in ensuring the health, safety and welfare of people. The provider had also failed to inform the Commission of serious injuries in line with their legal obligations.

Immediately after our inspection, the Commission requested the provider submit an urgent action plan to tell us how they would keep people safe and we also met with the provider. The provider told us they would stop new admissions to the service, in order for them to put things right. We also contacted the local authority safeguarding team who took prompt action to ensure people's health, safety and wellbeing. The local authority and Clinical Commissioning Group (CCG) took action to stop placing at to the service. During this inspection we looked to see if improvements had been made. We found action had been taken, but some improvements were still ongoing.

Waypoints Plymouth is owned by Waypoints Care Group Limited. The provider also owns two other care homes in Dorset. The service provides care and accommodation for up to 64 people. On the day of the inspection 52 people lived in the home. Placements by the local authority and CCG had recently recommenced.

Since our last inspection there was a new registered manager in post. 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.

The provider had designed, but had not yet implemented their new overarching governance framework, to help monitor the management and leadership of the service, as well as the ongoing quality and safety of the care people were receiving. This meant there was a continued risk to the ongoing quality of the service because the provider may not be alerted to when improvements are required.

The registered manager had devised some new systems and process to help monitor the quality of care people received. However, these had not always been robust in identifying areas requiring improvement, and still required embedding into culture and practice.

People's families were being asked to complete questionnaires to help collate their views with regards to the ongoing improvements at the service. Questionnaire returns were ongoing, with the registered manager reviewing each one when it was received.

There was a new management team in place. This included a new registered manager and a new head of clinical care. However, two external professionals felt strong leadership was still required in respect of the nursing team, to help radically change the nursing culture.

People and relatives spoke positively about the new registered manager and of the dramatic change in 'atmosphere'. Staff, had also seen changes within the service but recognised improvements were still ongoing.

The registered manager had worked tirelessly to make improvements at the service, and was passionate about ensuring people received a compassionate service. External professionals were supportive of the service, and of the registered manager's enthusiasm to make things better.

When mistakes were made, these were now learnt from and used to help improve the ongoing quality and safety of people. The provider and registered manager were open, transparent and admitted when things had gone wrong. The registered manager kept their ongoing practice and learning up to date. The provider had notified the Commission of significant events which had occurred in line with their legal obligations. For example, regarding safeguarding concerns and serious injuries.

People continued to live in an environment which was not free from offensive odours. Although, the provider had attempted to take action by changing cleaning products, on both days of our inspection there was a smell of urine in the reception area and in some bedrooms.

Overall, people's risks associated with their care were now recorded so staff knew how to support them, but their records were not always updated when changes occurred. This meant staff may not know how to support people safely. Staff, were not always observant to hazards that could result in people falling.

People were now protected from avoidable harm and abuse. People and their families told us they felt an improvement to the feeling of their safety. Since our last inspection people, along with the support of their families had been consulted about moving bedrooms. This was to help ensure people with similar needs were cared for in a safe way and in an environment conducive to their needs.

People were cared for by staff who had been safely recruited, and there were enough staff to meet people's needs. However, an external professional told us, further action was required to ensure the mix of clinical and social care staff, met with the needs of people, particularly with regards to dementia care.

People's medicines were now stored and administered safely and there was a system in place to help ensure the effective ordering and management of people's medicines.

Overall, people lived in an environment which had been assessed to ensure it was safe. However, in the activities room, cupboards were found to be unlocked which contained cleaning products which could be a risk to people should it be consumed.

The dining experience people received was observed to be of a variable quality. Whilst some people were supported by staff who displayed positive interactions, other people were not. People were not always offered a choice of what they would like to drink or assisted as needed. The dining tables were not always set to remind people of the time of day, and the menu displayed was not in a format that everyone may be able to understand. People were complimentary of the food.

Overall, people had their needs met by staff who had undertaken training. Changes, to dementia training were being implemented to help staff ensure were meeting the provider's philosophy of providing person centred care. An external professional told us, improvements were required in dementia training for all staff, because when they visited they did not always observe staff supporting people in line with dementia care principles.

Nursing competency continued to require improving. Although, staff undertook clinical training to help assist with their ongoing competency. Two external professionals told us, nursing competence in respect of both general and mental health nursing required improving. This was because they felt nursing staff did not carry out a continued individualised assessment of people's needs, to help ensure their care was pro-active rather than re-active.

People's consent to care had been sought and recorded in their care plans. The registered manager and staff understood their responsibility in relation to the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS).

People were supported to maintain their health and wellbeing by accessing external health and social care professionals.

People's environment had been re-designed to help reduce unnecessary instances of physical altercations between people. A new maintenance person had been recruited to help ensure repairs to the environment were carried out promptly.

People's privacy and dignity was now respected. The changes to the environment had greatly reduced the number of occurrences of people walking into other people's bedrooms uninvited.

People and their families told us staff, were kind. Compassion was shown by staff, who were observed sitting and talking with people. We saw staff holding people's hands, comforting people by placing an arm around them when they were upset, and walked with people around the home, whilst participating in meaningful conversation. People and/or their families told us they were involved in decisions relating to their care. Days, which were special to people such as birthdays were fondly remembered and celebrated. People's families were welcome to visit at any time.

People were now invited to come and talk about their concerns or worries, helping to reduce the need for people to complain formally. People's complaints were encouraged, spoken about positively, and were used to help improve the service.

People were supported at the end of their life to have a comfortable dignified and pain free death. Nursing staff liaised promptly with external professionals, and the local hospice ensuring a joined up approach to people's care.

People living with dementia now received personalised care and could participate in social events. However, two external professionals told us when they had visited, people were seen to be sat isolated in their bedrooms or walking aimlessly around the service and felt social engagement for people, was lacking. The registered manager told us, a new activities person had been employed and work to redevelop social engagement for people would be taking place.

People's independence was encouraged. People now had care plans in place for their health and social care needs. Care plans had been re-written and transferred onto a new computer system, but action was still ongoing to ensure people's care plans were person centred.

People's changing care needs were discussed throughout the day at handovers. Staff told us they felt well informed and there was now "better communication" between teams.

People's confidential information continued to not always be stored securely. Offices were sometimes left open and unattended. We spoke with the registered manager about this, who told us he would take immediate action to speak with staff about the importance of locking office doors.

We recommend the provider carries out a review of clinical competence and leadership within the service. In line with best practice, set out by the Royal College of Nursing (RCN) and the Nursing and Midwifery Council (NMC). We also recommend the provider reviews the dining experience within the service. Taking account of best practice and dementia research.

Full information about CQC's regulatory response to the more serious 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?

Requires Improvement ●

Aspects of the service were not safe.

People were not fully protected for risk associated with their care.

People continued to live in an environment which was not free from odour.

People were now protected from avoidable harm and abuse.

People were cared for by staff who had been safely recruited, and there were enough staff to meet people's needs.

People's medicines were now managed safely.

Is the service effective?

Requires Improvement ●

Aspects of the service were not effective.

People were not always adequately supported at meal times.

People were supported by staff who had received training in order to meet their individual needs.

People Nursing competency continued to require improving, because advice was regularly sought from external professionals relating to basic nursing care, such as skin care and continence.

People's legal rights were upheld consent to care was sought in line with guidance and legislation.

People were supported to maintain their health and wellbeing.

Is the service caring?

Good ●

The service was caring.

People's privacy and dignity was now respected.

People's confidential information continued to not always be stored securely, because office doors were sometimes left open.

Overall, people were supported by staff who, showed kindness and compassion.

People and/or their families were involved in decisions relating to their care.

People were supported at the end of their life to have a comfortable and dignified death.

Is the service responsive?

Good ●

The service was responsive.

People were supported to take part in social activities.

People now had care plans in place which provided guidance and direction to staff about how to meet their individual needs.

People living with dementia were now provided with personalised care.

People's complaints were now seen positively, investigated robustly and used to help improve the service.

Is the service well-led?

Requires Improvement ●

Aspects of the service were not well-led.

People did not live in a service which was monitored by the provider to help ensure its quality and safety.

The registered manager had devised some new systems and process to help monitor the quality of care people received. However, these had not always been robust in identifying areas requiring improvement.

People, relatives, external professionals and staff spoke positively about the new registered manager and of the dramatic change in 'atmosphere', and strong leadership at the service.

When mistakes were made, these were learnt from and used to help improve the ongoing quality and safety of people.

The registered manager kept their ongoing practice and learning up to date to help develop the team and drive improvement.

Waypoints Plymouth

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 visited the care home unannounced on 29 September 2017, 02 and 03 October 2017. The inspection team consisted of one inspector, a specialist advisor of nursing care for older people and an expert by experience - this is a person who has personal experience of using or caring for someone who uses this type of service. The inspection team also consisted of two pharmacy inspectors.

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 also contacted Healthwatch Plymouth, the local authority quality and service improvement team, and the Clinical Commissioning Group (CCG). Their feedback can be found through-out the inspection report.

During our inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed how people spent their day, as well as people's lunch time experience.

We spoke with four people who lived at the service, six relatives, 15 members of staff, the head of care, registered manager and the provider's nominated individual (NI). A nominated individual is responsible for ensuring the services provided by the organisation are properly managed.

We looked at ten records which related to people's individual care needs. We also looked at records that related to people's medicines, as well as documentation relating to the management of the service. These included auditing records, policies and procedures, accident and incident reports, training records, equipment and serving records, and kitchen menus.

After our inspection we contacted a nurse practitioner, and a mental health specialist nurse assessor, for

their views about the service. We have included their views in the body of the report.

Is the service safe?

Our findings

At our last inspection on 27 and 28 February 2017 we rated this key question as Inadequate because, improvements were required to ensure risks to people's care needs were recorded and known by staff, to help ensure people could be cared for safely. We also asked people were protected from avoidable harm and abuse, had access to their call bell, lived in an environment free from offensive odour and that their medicines were administered as prescribed. During this inspection we looked to see if improvements had been made. We found action had been taken, but improvements were still ongoing and required more time to demonstrate they continued and could be sustained

People continued to live in an environment which was not free from odour. On both days of our inspection there was a smell of urine in the reception area and in some bedrooms. Two external professionals told us when they had visited there was also smell of urine. The registered manager explained, since our last inspection they had changed their cleaning products which had greatly helped, but there had been a recent delay in the delivery of the product. The registered manager also told us new carpets and changes to flooring were being considered. During our inspection a delivery arrived, and we noticed a slight decrease in the odour when the product had been used. On this occasion, people and their families did not comment about the odour and told us they felt the environment was odour free, clean and tidy.

People were protected from avoidable harm and abuse. Since our last inspection people, along with the support of their families had been consulted about moving bedrooms. This was to help ensure people with similar needs were cared for in a safe way and in an environment conducive to their needs. Without exception, people, families, staff and external professionals told us of the positive impact this has had, on protecting people from harm, and in reducing the number of safeguarding alerts to the local authority. One member of staff described the change as, "Amazing change of environment. We haven't got the vulnerability. We can be more observant now". One relative told us, "The problems are not all gone, but you've got to give him (the registered manager) time. The registered manager told us it had been a challenging but successful piece of work. It was apparent the environmental changes had been carried out with professionalism, and with sensitivity. The registered manager explained, they were still liaising closely with some families in order to support their loved ones to move to a bedroom more suited to their needs. The registered manager recognised they could never alleviate people from ever walking into other people's bedrooms. However, the significant environmental changes and the effective use and monitoring of people's sensor/alarm mats had greatly reduced the occurrences. Safeguarding referrals to the local authority and statutory notifications of abuse to the Commission had significantly reduced. Feedback from the local authority was that on the whole, alerts were closed because the provider had taken appropriate preventive measures to protect people. This meant, learning from safeguarding incidents was put into practice to keep people safe, and helped improve the service.

People were also protected from abuse because staff had received safeguarding training, and were able to tell us what they would do if they suspected someone was being abused or mistreated. Staff were confident if they needed to report any allegation of abuse, action would be taken by the registered manager, but also knew they could contact other agencies should they feel it necessary. The registered manager had taken

time to educate staff by designing posters which would help prompt staff to take the right action, when required.

Overall, people told us they felt safe living at the service, telling us "I feel safe because of the (sensor) mat", "Residents still come into my room, but not as much but they used to" and "I've got staff coming in to see if I'm alright all the time". Relatives told us, "The security around the place is good" and "People wandering into my wife's room just doesn't exist anymore since the manager changed people around".

Overall, people's risks associated with their care were recorded so staff knew how to support them but some improvements were still needed. People who expressed behaviours that may challenge others were effectively supported by specific care plans. Records were in place to record their behaviour so themes and trends could be identified to help adapt their care and support, or help get the person the right external professional advice. However, when there was change in the risk to people's care and support needs, their care records were not always updated to reflect the change. For example, when two people had fallen, the preventative measures to reduce the re-occurrence had not been transferred from the daily entry in a person's notes to the related care plan and risk assessment. This meant, there could be a possibility of them falling again, because staff did not have the most up to date recorded information about how to support them safely. The registered manager took immediate action to improve this, by introducing an accidents and incidents flow chart for staff to follow to help guide staff to update records when changes occurred.

People were not always protected from hazards that could result in them falling. For example, one person was supported to walk independently, by two members of staff by their side. However, the person's trousers were too long, and were dragging on the ground which meant they could have tripped. We spoke with the staff and registered manager about what we had observed, and they agreed this should have been noticed and told us action would be taken to share this feedback with the staff team.

People, who were able to use a call bell to ask for assistance now had one in their reach, and to help ensure it was always in their reach staff checked periodically through-out the day and recorded their checks. Those people who were unable to use such equipment were vigilantly checked by staff throughout the day to help ensure their comfort and safety. One relative told us, "There's always a quick response to his call bell".

People were cared for by staff who had been safely recruited, and there were enough staff to meet people's needs. Since our last inspection, the registered manager was developing a staffing dependency tool to help ensure staffing met with people's individual care plans. One to one staffing was also provided when a person was deemed to be at high risk of falling or of social isolation. An external professional told us, further action was required to ensure the effective deployment of clinical and social care staff, met with the needs of people, particularly with regards to dementia care. This would mean there would be a better mixture of specialist expertise to deliver high quality and individualised care. External professionals had already shared their feedback with the registered manager, who was already taking action to review the staffing complement within the service.

People's medicines were stored and administered safely and there was a system in place to help ensure the effective ordering and management of people's medicines. Nursing staff received an assessment of their ongoing competence. The registered manager had fostered positive working relationships with the medicines team from the Clinical Commissioning Group (CCG), and their local supplying pharmacy. The medicines policy was being reviewed to consider current best practice guidance, and documentation was being updated regarding covert medicine administration and medicines prescribed to be given 'when required'.

Overall, people lived in an environment which had been assessed to ensure it was safe. Fire tests were carried out and equipment was serviced in line with manufacturer's requirements. People had personal emergency evacuation plans in place (PEEPs). These helped to give a summary of people's individual needs for the emergency services in an event such as a fire. However, in the activities room, cupboards were found to be unlocked which contained cleaning products which could be a risk to people should it be consumed. We informed the registered manager about this who told us preventive action would be taken, either by removing the items or by locking the doors.

Is the service effective?

Our findings

At our last inspection on 27 and 28 February 2017 we rated this key question as requires improvement because, improvements were required to ensure staff training was embedded into practice, clinical competency was assessed and people's nutritional needs were recorded so staff knew how to support them. During this inspection we looked to see if improvements had been made. We found action had been taken, but improvements were still ongoing and required more time to demonstrate they continued and could be sustained.

The dining experience people received was observed to be of a variable quality. Whilst some people were supported by staff who displayed positive interactions, five people were not. Five people were observed to not be offered a choice of what they would like to drink. The dining tables were not always set to remind people of the time of day, and the menu displayed was not in a format that everyone maybe able to understand. Practice which is important in services which specialise in supporting people with dementia.

One person was observed to be supported with her pudding, but was not told what the pudding was prior to the staff member giving the person a spoonful. The person shouted out "No my love" and had decided that they did not like the pudding offered. However, the member of staff then failed to offer an alternative and walked away. This person was unable to leave the table herself, so was left for 20 minutes before a member of staff noticed that the person was slipping down in their chair, was uncomfortable and required assistance. People, who had a pureed diet, had their meal displayed attractively on the plate however, were not always told what the meal was prior to being assisted. We spoke with the registered manager about our observations who took action to speak with staff.

By day two immediate action had been taken to improve the dining experience. People were offered a choice of drink, the menu had been displayed in a pictorial format and tables were dressed to help people distinguish the time of day. These improvements were positive, however one person who was blind was observed to shout loudly for assistance, was ignored, and then later taken away from the dining room. The registered manager told us this was not acceptable. They explained, they had already recognised improvements were required, and with the head of care, had commenced an observation of the dining experience to help identify the necessary action required.

An external professional also told us, when they had visited the service recently they had observed three meals left out on the side. This meant people's meals were getting cold. They told us they had mentioned this to the registered manager, so improvements could be made.

We recommend the provider reviews the dining experience at the service. Taking account of best practice and dementia research.

People could have their meals at times to suit them, and were complimentary of the food, commenting, "The food is good, which I'm happy about as I have a good appetite", "There's nothing wrong with the food at all", and "I'm happy with the food". Relatives also confirmed this by telling us, "The food they serve is

exceptionally good", "Dad has a good appetite, and I know he enjoys his meals" and "Mum loves her food". One relative had written to the chef to tell them, "I feel it is no small achievement for you and your staff to be providing food of such a high quality under conditions where there are so many variables every hour of the day".

People now had their nutrition, such as swallowing difficulties appropriately assessed by speech and language therapists (SLT), and information about their diet was shared effectively within the staffing team. The chef explained how they never altered people's diets without receiving written confirmation from a nurse.

Staff received an induction prior to commencing their role, to introduce them to the provider's ethos and policy and procedures. As well as with training the provider had identified as being essential to ensure people's individual needs were met, such as safeguarding, fire, and dementia care. The provider's induction had been designed in line with the Care Certificate. The care certificate is a nationally recognised qualification for care workers new to the industry

Overall, people had their needs met by staff who had undertaken training. However, an external professional told us, improvements were required in dementia training for all staff, because when they visited they did not always observe staff supporting people in line with dementia care principles. This had already been recognised, and the training manager who was up to date with the best and most current practice, was keen to tell us about important changes to the dementia course, explaining to us "I am taking them (the staff) back to basics; I don't just want them to understand the theory. A move towards empathy and an understanding of how people living with dementia may feel".

One member of staff told us, "We have so much training". Staff also completed training in courses which helped them to individually meet people's needs, such as nutrition, person centred and dementia care. The provider's training manager was also responsible for mentoring and supporting staff, by carrying out one to one supervision and observation of practice. We observed some improvement in staff interactions, helping to demonstrate the principles of person centred training. For example, when staff knew something about a person's history, they used this to prompt conversation.

Nursing competency continued to require improving. Although, staff undertook clinical training to help assist with their ongoing competency and revalidation. Revalidation is the process by which nurses have to demonstrate continued knowledge and competence in order to retain their formal nursing registration with the Nursing and Midwifery Council (NMC). Two external professionals told us, nursing competence in respect of both general and mental health nursing required improving. This was because they felt nursing staff did not carry out a continued individualised assessment of people's needs, to help ensure their care was proactive rather than reactive. Advice was also regularly sought from external professionals relating to basic nursing care, such as skin care and continence. This demonstrated some nursing staff may be in need of further training. They also felt there needed to be more professional accountability and stronger leadership within the nursing team.

We recommend the provider carries out a review of clinical competence and leadership within the service. In line with best practice, set out by the Royal College of Nursing (RCN) and the Nursing and Midwifery Council (NMC).

People's consent to care had been sought and recorded in their care plans and staff, were heard to verbally ask people for their consent prior to supporting them, for example before assisting them with their lunch or with their medicines. As part of the overall environmental changes at the service, people and their families

had been consulted prior to moving rooms. Meetings had been held to help inform, encourage people to be part of the changes, and to obtain their formal consent.

The registered manager and staff understood their responsibility in relation to the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). Best interest meetings had taken place when required and the details and outcome of these meetings had been recorded in people's care plan. People's care plans recorded their mental capacity had been assessed when required, and that DoLS applications to the supervisory body had been made when necessary. Staff had received training in respect of the legislative frameworks.

People were able to freely move around the service, and the internal garden was secure. But, action had been taken to divide the service into separate units, by putting locks on connecting doors. At times these doors were locked when they considered people may be at risk of harm. However, in line with the MCA, the registered manager had made sure there was a policy in place regarding the locking of each door, which staff told us they were aware of. People, their families, the local authority and mental health team had all been consulted.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People were supported to maintain their health and wellbeing by accessing external health and social care professionals, and people's records demonstrated when such professionals had been contacted.

People's environment had been re-designed to help reduce unnecessary instances of physical altercations between people. The nursing desks in corridors, which had previously been a place for people to congregate around and become unsettled, had been removed and replaced with comfortable seating. On day two, the downstairs dining area, which had been cluttered on day one, had been tidied up, with a new seating area being created. A new maintenance person had been recruited to help ensure repairs to the environment were carried out promptly. One member of staff told us, "He's so good. You ask him to do something and it's done. He's so responsive".

Is the service caring?

Our findings

At our last inspection on 27 and 28 February 2017 we rated this key question as Requires Improvement because, improvements were required to ensure people's privacy and dignity was promoted, their privacy respected, and people's confidential records were locked away securely. We also told them they must make improvements to support people in an individual and personalised way. During this inspection we looked to see if improvements had been made. We found action had been taken, but improvements were still ongoing and required more time to demonstrate they continued and could be sustained.

People's privacy and dignity was now respected. The changes to the environment had greatly reduced the number of occurrences of people walking into other people's bedrooms uninvited. When this did happen staff were quick to respond, and gently guided people out. Staff members knocked on people's doors before entering and people told us doors and curtains were closed for privacy and dignity, when they received personal care.

People and/or their families told us they were involved in decisions relating to their care. Families were invited to care reviews, and a new nursing key worker system had been introduced to help ensure families had a contact within the service, should they have any questions or worries about their loved ones care. An external health professional told us people's families were now being involved in their loved ones' dementia care review.

Overall, people were now supported by staff who showed kindness and compassion. People's comments included, "I'm very happy with my care, the staff are lovely", "Staff always have time for me", "The staff just talk to me so calmly, I love them". Relatives told us, "Dad loves the staff to bits", "The care is perfect", "Even the laundry staff show compassion", and "There's a good caring attitude from the staff". Following our inspection a relative contacted us to tell us, "My reason for writing to you is that in the last few weeks the care at both (care staff) and nursing levels has been excellent. I told (the manager) today that the improvement in care quality that he is achieving is going from strength to strength, and I thought I should say the same to you". However, improvements to how people were supported during meal times required improving.

Staff, were observed sitting and talking with people. We saw them holding people's hands, comforting people by placing an arm around them when they were upset, and walking with people around the home, whilst participating in meaningful conversation. When people repeated themselves, staff listened and engaged, as though they were hearing what the person was saying for the first time. A relative had written to express the kindness shown by staff telling the registered manager, "The whole feel as you enter the building is one of inclusion, care and concern. The ladies at reception are always smiling and welcoming. I have yet to find any member of staff who is not the same. Completely embracing and warm. I commend them all".

People's bedrooms were personalised, and people, if they had consented to, had their name or a special photograph on their door to remind them that it was their bedroom. Days, which were special to people such as birthdays were fondly remembered and celebrated. One relative had written to thank the staff

commenting, "It was great to see a gathering for cake cutting and singing....The cake was delicious and beautifully presented. A lot of effort went into making the huge card which arrived just before lunch...with all the staff signatures, together with the flowers. I was so grateful for all the goodwill and hard work which went into making this a happy day".

People looked smart, clean and had a tidy appearance. One member of staff, had taken the time to style a person's hair in a 'french plait'.

People's families were welcome to visit at any time, offered cups of tea and invited to have a meal with their loved one. Families, if they wanted to, were empowered to be part of their loved ones care. For example, we saw two relatives support their loved one at lunch time.

People were supported at the end of their life to have a comfortable dignified and pain free death. Nursing staff liaised promptly with external professionals, and the local hospice ensuing a joined up approach to people's care. One family had taken the time to express their thanks on the carehome.co.uk website, detailing "My father was a resident at Waypoints for the last ten days of his life. The care that he and we the family received from the management, nurses and carers was remarkable. Each and every member of staff took the time to get to know us all. They were endlessly attentive not only to Dad's needs, but to ours as well. The nursing staff liaised with doctors to ensure that pain relief increased at the appropriate rate. Care staff maintained Dad's comfort and dignity throughout. The guest room allowed my brother and I to be with our father constantly for his last few days which now gives us great comfort".

People's confidential information continued to not always be stored securely. Offices were sometimes left open and unattended. We spoke with the registered manager about this, who told us he would take immediate action to speak with staff about the importance of locking office doors.

Is the service responsive?

Our findings

At our last inspection on 27 and 28 February 2017 we rated this key question as Requires Improvement because, improvements were required to ensure people's care records were up to date and reflective of how they wanted their care and social needs to be met. We also told the provider to ensure people living with dementia received personalised care and were effectively supported with their continence needs. During this inspection we looked to see if improvements had been made. We found action had been taken, but improvements were required to ensure people received personalised support with their nutritional needs.

Overall, people living with dementia now received personalised care. For example, one person liked to carry many personal belongings around. Staff saw this was causing mobility difficulties and was sometimes causing behavioural challenges to others so they gave the person a trolley on wheels which they could use to safely transport their belongings. This had made it easier for the person and had reduced the occurrences of unexpected behavioural changes towards others. For another person, it had been recognised they became frequently anxious about losing their handbag and money. A number of handbags and purses had been bought from a charity shop, and paper money placed inside and staff made sure the person always had a handbag and purse with them. This had helped to alleviate the person's ongoing anxieties. People had care plans in place relating to their dementia, so staff could support them effectively. One relative had written on the carehome.co.uk website that, "Although many of the residents have challenging behaviour, it is a surprisingly calm atmosphere and very well managed". However, further training was required to ensure people received personalised care and support with their nutrition, because staff did not always follow the basic principles of dementia care.

People had care plans in place for their health and social care needs. Since our last inspection, care plans had been re-written and transferred onto a new computer system and ongoing work was taking place to help ensure care plans were individualised to people's needs. The new system helped to prompt staff when reviews of individual care plans were due. Staff told us this had been beneficial, and felt care plans, were now more up to date and reflective of people's needs.

People's continence needs were now managed well, and a member of staff with expertise in continence care had been appointed, and had taken organisation of assessments and continence products. The member of staff was keen and passionate about people's continence, making sure people had the right aids and enough supply.

People's independence was encouraged. Staff told us how they supported people to choose their own clothes. They also explained how one person who liked to walk, but became very tired was assisted from their bedroom to the dining room by a wheelchair, and then encouraged and supported to walk back. A relative had taken time to write to thank the registered manager and staff for improving the quality of their Dad's life, telling them "I have to say that my Dad has not looked as bright and happy for such a long time. I really was beginning to live every day broken hearted as I saw him deteriorate little by little...I could not describe the contrast I see now. Please, please let them know how much we have seen Dad improve. This is directly attributed to the skill, compassion and care from your team. They really need to be proud of

themselves".

People's changing care needs were discussed throughout the day at handovers, staff told us they felt well informed and there was now "better communication" between teams. There was improved joint working with an external nurse practitioner, which was helping to ensure people's clinical care plans were up to date. An external professional told us, since our last inspection staff were now happier and showed an enthusiasm to try new ways in which to support people.

Overall, people could participate in social events. On the days of our inspection, people took part in one to one activities, group activities, or chose to spend time on their own. Some people enjoyed a film and were offered an ice cream cone to enjoy whilst they watched. Photographs were displayed showing recent activities such as cake making, pet visits, carpentry and a recent visit from a local school. People told us, "I enjoy it when the lady brings her pets in for us to stroke" and "I loved it when the schoolchildren came to visit, it was lovely to see them". However, two external professionals were not as positive. They told us they felt social engagement for people living with dementia was lacking. This was because when they had visited they had observed people to be sat alone in their bedrooms, and/or walking about the service. Staff did not always engage, or recognise that people may wish stimulation. The registered manager told us, a new activities person had been employed and working to redevelop social engagement for people to ensure it met with people's individual dementia care needs. But they also explained, that dementia research showed walking should not always be seen as a lack of stimulation but, maybe connected with a person's type of dementia.

People were now invited to come and talk about their concerns or worries, helping to reduce the need for people to complain formally. One example of how the manager was trying to encourage open communication was by introducing 'coffee with the manager' drop in sessions. This encouraged families to come and speak with him on a weekly basis. Families had raised a variety of issues which the registered manager was trying hard to improve, such as ensuing better communication with families and staff amongst the team.

People's complaints were now encouraged, spoken about positively, and were used to help improve the service. Relatives told us the registered manager "listened" and "took prompt action". One example of this was the introduction of a new system for receiving and handling post. This had been introduced because relatives had been concerned about their loved one missing health appointments, because their post had not been opened in time.

Is the service well-led?

Our findings

At our last inspection on 27 and 28 February 2017 we rated this key question as Inadequate because the provider had failed in their responsibility to monitor the service and provide good leadership, which had ultimately lead to the deterioration of the service and the failure to meet regulations. Therefore, we told the provider to make improvements to ensure the service was well-led, and that the ethos and culture was positive and empowering. When mistakes were made, these were to be learnt from and used to help improve the ongoing quality and safety of people. We also told the provider to have effective systems and processes in place to help monitor the service, and identify where improvements were required, both within the service, but also embedded into practice at a provider level. In addition, we requested improvement in the submissions of statutory notifications. We found action had been taken, but improvements were still ongoing and required more time to demonstrate they continued and could be sustained.

We asked the registered manager for a copy of their governance policy, but we were told there was no policy in place. However, on day two of our inspection, a new 'good governance policy' was sent by the provider to the registered manager. Although, we were pleased to receive this, it was disappointing, that given the previous breach of regulation in relation to assessing and monitoring the quality of the service that the policy was not already in place and known by the registered manager and understood by staff.

The policy described the providers governance framework, and detailed the provider would be responsible for ensuring "Regular audits...had been completed" and a new comprehensive audit had been created using the Commissions key lines of enquiry (KLOE) framework. This would help the provider to have an overarching awareness of the service. The registered manager, who also saw the policy for the first time, told us they were encouraged by it and explained how the provider would be discussing the policy in further detail at the next internal managers' meeting. Following the inspection, we spoke with the nominated individual who told us consultations had concluded, and the policy had now been finalised and implemented. As neither Director had a nursing qualification, we were told the clinical governance would be carried out by a team of staff with clinical qualifications, with one of the Directors having oversight and accountability.

The nominated individual explained how they had recognised the importance of good governance, in helping to ensure the quality of leadership, a positive culture and in meeting regulations. However, because the provider was yet to implement their governance framework it was not clear how the provider was currently ensuring regulations were being fully met and the culture reflected the provider's ethos, vision and values of being a service that was "Person Centred".

Monthly management meetings were now taking place to improve communication and to share learning. The provider told us their management team visited the home regularly. This included the director of operations visiting approximately three times a month to review operational issues, and the financial controller and management accountant visiting the service on a monthly basis, for a finance meeting. The nominated individual, who was the provider's managing director, also visited the service approximately once a month. However, one member of staff told us when one member of the management team had

visited, the member of staff had been ignored. We spoke with the nominated individual about this, who told us they would address this.

The provider explained better relationships with stakeholders were now being fostered. For example, as well as informing the registered manager, the local authority was now informing the provider directly of any concerns that they may have.

People's families were being asked to complete questionnaires to help collate their views with regards to the ongoing improvements at the service. Some comments included, "There are still some poor standards which have been accepted and these need to be raised. E.g. teeth cleaning, nails, shave. I am confident with good leadership, strong positive role modelling improvements will soon occur. These are starting to be seen and the mood of the home is lighter". "It now feels like a happy home to me. I do reiterate the handover/communication need to improve". The registered manager was using this feedback to help drive improvements at the service.

The registered manager had devised some new systems and process to help monitor the quality of care people received, such as accidents, incidents and care planning. The registered manager told us, "When we see a pattern forming we deal with it". However, these had not always been robust in identifying areas requiring improvement, and still required embedding into culture and practice. For example, gaps in records relating to people's care, clinical competency and leadership and supporting people's nutrition.

The provider's governance framework, to help monitor the management and leadership of the service, as well as the ongoing quality and safety of the care people were receiving had not been fully implemented. Some newly designed systems had not always been robust in identifying areas requiring improvement. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a new management team in place. This included a new registered manager and a new head of clinical care. The introduction of this new management team had created a positive and empowering culture. External professionals felt strong leadership was required in respect of the nursing team, to help radically change the nursing culture.

People and relatives spoke positively about the new registered manager and of the dramatic change in 'atmosphere', and strong leadership at the service. People commented, "The manager has made a big difference", "You can go to the manager just for a chat" and "You see the manager walking around the home every day". Relatives told us, "We had a relatives meeting recently and I was listened to", "I think he can and will get there", and "The manager is brilliant and the carers are perfect". A relative had written to the registered manager to tell them, "We can see/feel improvements at the home since you have taken over so big thanks to you and all the staff so far".

Staff, had also observed changes within the service but recognised improvements were still ongoing. They told us the atmosphere of the service was positively "different" "(the manager) is amazing...the morale is so much better. People look forward to coming to work" and "What an absolute difference". Staff also told us, "I love it, it's so much better, but it's not there yet. In the past when I reported things to management nothing was done. The new manager is brilliant he listened, observed and sorted issues. I feel totally valued". Another member of staff stated, "It's improving, there are lots of positives, staff need direction, they (managers) are very open and approachable, I feel valued". The registered manager was taking time to embed the providers vision and values into the service, by ensuing effective remodelling, speaking with staff on a one to one basis or in group supervision.

External professionals told us the new manager, "listened". They also recognised the improvements within the service but expressed the service was "not there yet" and that they had "a long way to go". External professionals were supportive of the service, and of the registered manager's enthusiasm to make things better.

The registered manager had worked tirelessly to make improvements at the service, and was passionate about ensuring people received a compassionate service. They were realistic about embedding change into staffs' practice and recognised improvements were ongoing. The registered manager told us they felt supported by the provider. There was no formal process in place for one to one supervision, but as a management group, the registered manager told us they met on a monthly basis. They told us, they could always contact the provider and that they always received a prompt response.

We spoke with the nominated individual about management support. The nominated individual told us, the registered manager had received an appraisal three months into his employment, instead of the usual six months. This was to help ensure the registered manager was suitably supported, given the service was in 'special measures'. One of the Directors also visited the home on a weekly and/or monthly basis, and also spoke with the registered manager on a daily basis. However, because their visits were not always recorded; this meant, the provider was unable to demonstrate how their communication with the registered manager, and their presence within the service, fitted into their overarching governance framework, in ensuring the effective monitoring and leadership of the service.

When mistakes were made, these were now learnt from and used to help improve the ongoing quality and safety of people. The provider and registered manager were open, transparent and admitted when things had gone wrong. This demonstrated their 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. One relative commented, "(the manager) has been very honest. He called a special meeting to discuss the findings of the last CQC inspection".

The registered manager kept their ongoing practice and learning up to date. The registered manager told us they enjoyed attending events such as the dignity in care forum and the local manager's network. These helped to share best practice, experiences and to learn from each other. The registered manager told us it was useful meeting other registered managers, who were also managing services in 'special measures' to seek ideas and advice.

The provider was now notifying the Commission of significant events which had occurred in line with their legal obligations. For example, regarding safeguarding concerns and serious injuries.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Regulation 17 (1) (2) (a) (b) (c) (f) The provider's governance framework, to help monitor the management and leadership of the service, as well as the ongoing quality and safety of the care people were receiving had not been fully implemented. Some newly designed systems had not always been robust in identifying areas requiring improvement.

The enforcement action we took:

We imposed a condition on the providers registration.