Gloucestershire Old People's Housing Society Limited

Gloucestershire Old Peoples Housing Society

Inspection report

Watermoor House
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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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection was completed on 25 and 29 January 2018 and was unannounced.

Gloucestershire Old Peoples Housing Society is better known as Watermoor House and will be referred to as such throughout this report.

Watermoor 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. Watermoor House accommodates 39 people in one adapted building. There were 31 people at Watermoor House at the time of the inspection.

There was no registered manager in post at the service as the previous registered manager had left their post two months before the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager had started working at the service and was in the process of registering with the Care Quality Commission.

The previous inspection was completed in April 2017 and the service was rated 'Good' overall. At this inspection we found a number of concerns and the service was rated 'Requires Improvement' overall. Following the inspection, the manager informed us about some of the measures they had implemented immediately following our inspection to drive improvement. This included actions such as weekly audits of people's care plans and liaising with the local authority for further staff training.

Risk assessments were not always updated to ensure people were supported in a safe manner and risks were minimised. Where people had suffered an accident, sufficient action had not been taken to ensure the ongoing safety of the person. The admissions process was not robust and did not ensure the staff had all relevant information related to the care of people being admitted to the service.

Staff had received training and supervision appropriate to their role however this had not always been effective in providing staff with the skills they needed to support people effectively. Although staff sought consent and gave choice to people, the service was not always adhering to the principles of the Mental Capacity Act 2005 (MCA). As a result, people were not always supported to have choice and control over their lives.

Improvements were required to ensure people's care plans and associated documents were person centred and clearly reflected their current level of need. Where complaints had been raised, these had been managed appropriately.

Governance systems had been established in the service but these were not effective in identifying and

rectifying shortfalls in the service. There were policies and procedures in place and these had all been updated and reviewed regularly however; these were not always used by the manager or staff.

Staff had received training around safeguarding and were confident to raise any concerns relating to potential abuse or neglect. The administration and management of medicines was safe. There were sufficient numbers of staff working at Watermoor House. There was a robust recruitment process to ensure suitable staff were recruited. People could choose what they liked to eat and drink and were supported on a regular basis to participate in meaningful activities. People we spoke with told us the staff were caring and kind. People were given information about the service in ways they wanted to and could understand. There were positive comments from people, relatives and staff regarding the manager.

This is the first time the service has been rated Requires Improvement.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations 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

The service was not always safe.

Risk assessments were not always updated to ensure people were supported in a safe manner and risks were minimised.

Where people had suffered an accident, sufficient action had not been taken to ensure the ongoing safety of the person.

Staff had received training around safeguarding and were confident to raise any concerns relating to potential abuse or neglect.

The administration and management of medicines was safe.

There were sufficient numbers of staff working at Watermoor House.

There was a robust recruitment process to ensure suitable staff were recruited. People told us they felt safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training and supervision. However, staff competency was not being assessed to ensure they had the skills and knowledge to support people effectively.

Staff did not have a good understanding of the Mental Capacity Act (MCA) and people who could not consent to their care did not always have their rights upheld.

People could choose what they liked to eat and drink.

Is the service caring?

Good

The service was caring.

People we spoke with told us the staff were caring and kind.

People were supported in an individualised way that encouraged

them to be as independent as possible

People were given information about the service in ways they wanted to and could understand.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Improvements were required to ensure people's care plans and associated documents were person centred and clearly reflected their current level of need.

People were receiving end of life care.

Where complaints had been raised, the concerns had been addressed appropriately.

People were supported on a regular basis to participate in meaningful activities.

Is the service well-led?

Requires Improvement

The service was not well-led.

Governance systems were not effective in identifying and rectifying shortfalls in the service. The provider had not identified that people were at risk of receiving unsafe care so that action could be taken to mitigate this risk.

There were policies and procedures in place and these had all been updated and reviewed regularly however; these were not always used by the manager or staff to ensure people always received care in accordance with current best practice.

There were positive comments from people, relatives and staff regarding the manager.

Gloucestershire Old Peoples Housing Society

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 was prompted in part by notification of an incident following which a person using the service was admitted to hospital. This incident is subject to an investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC indicated potential concerns about the management of people's deteriorating health conditions and associated risks. This inspection examined those risks.

This inspection took place on 25 and 29 January 2018 and was unannounced. Inspection site visit activity started on 25 January 2018 and ended on 29 January 2018. It included looking at records, visiting people who use the service, talking with staff and phone calls and emails to relatives and health professionals. The inspection was completed by two adult social care inspectors and an Expert by Experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at the records of four people using the service. We spoke with two directors of the service, the manager and five members of care staff. We spoke with eight people living at Watermoor House. We contacted five relatives who gave us feedback on the service provided at Watermoor House. We spoke to four health and social care professionals who have regular contact with the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. One person said, "I am safe." Another person said "We are safe. The staff are good and help us stay safe." Staff told us they were able to keep people safe. One staff member said, "If there was a problem I would raise this with the manager or one of the team leaders. There is always someone to support us". The majority of the relatives we spoke with told us they felt their family member was safe at Watermoor House. One relative commented how they did not feel the staff and management had been able to maintain their family member's safety leading to deterioration to their health and subsequent hospital admission.

Although people told us they felt safe we found the provider's risk management systems were not always implemented effectively and we could not be satisfied the care people received was always safe.

Risks to people's health and safety had not always been reviewed as their needs changed to ensure their risk management plans would remain current and staff would have the information they needed to keep people safe. The four people's risk assessments we looked at had not been updated for at least two months. This had resulted in risks to their health not always being reviewed or identified when there were signs that their health and mobility were deteriorating. For example, one person's care records reported deterioration in the condition of their skin. It was noted that their skin appeared to be fragile and bleeding. However, their skin risk assessment had not been reviewed or updated to assess the risk of their skin breaking down and pressure ulcers developing. We discussed this with the registered manager and provider who told us they used a number of systems such as body maps and people's daily care records to record this information. However, these documents did not always link with people's risk assessments and did not allow the manager or staff to fully analyse and manage ongoing risk or further deterioration to people's health conditions.

Staff did not always identify, monitor and respond to peoples changing needs and increased levels of risk. For example, people did not always receive the support they required to ensure the risks to their health and safety were mitigated following a fall. We found records of five people who had suffered recurrent falls over the past six months. Risk assessments detailed some measures to keep people safe from falls, however the risk management plans for these people who had fallen repeatedly, had not been evaluated after each fall to ensure they were still effective in reducing the likelihood of them falling or suffering any injuries. For example, incident reports showed one person had fallen six times between November 2017 and January 2018. However, their care plan had not been updated to note they had a fall and their falls care plan had not always been reviewed following a fall. This would be good practice to determine whether the risk management plans in place were still sufficient and whether additional safeguards, health professional input or checks for people at high risk of falling were required. Staff might therefore not have up to date information to support people experiencing recurrent falls to mobilise safely.

We discussed these with the manager who told us that although there was a falls policy in the service, it was not being implemented and there was no systematic monitoring and evaluation of risk when people suffered recurrent falls. Accident and incident forms were brief and did not provided sufficient information

to judge whether the correct procedures had been followed and whether the fall was preventable. However, we did observe people who had mobility difficulties and were at risk of falling being supported safely by care staff during our inspection.

When people fell staff contacted emergency services when they found people had suffered injuries however people who did not have obvious injuries following a fall were not routinely monitored to ensure they remained safe. The provider's post falls guidance instructed staff to continue to observe people regularly for at least 72 hours following a fall to ensure any injuries that might not be immediately visible were identified. Records showed that these observations had not taken place. The manager acknowledged that this had been a failing within the service to follow their falls policy. This meant staff might not always have identified any falls related injuries that might not be immediately visible and required prompt treatment from healthcare professionals

Accident and incidents was not always fully investigated to ensure staff had taken appropriate action for example, when people fell, so that safeguards could be implemented to minimise the risks of people falling again. Where people had suffered an injury, the cause had not been fully determined. This did not enable the service to implement appropriate actions to ensure people's safety in the future and to determine that staff followed the provider's safety guidance appropriately.

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

Staff received training on how to recognise abuse and how to report allegations and incidents of abuse. Policies and procedures were available to everyone who used the service. The manager and staff recognised their responsibilities and duty of care to raise safeguarding concerns when they suspected an incident or event that may constitute abuse. Agencies they notified included the local authority, CQC and the police. One staff member said, "If I have any concerns, I will raise these with the manager." Staff members told us about their confidence in the manager's ability to investigate and respond appropriately to safeguarding concerns. Staff told us they were confident to report any concerns to the local authority or CQC if they felt appropriate action was not taken by the manager.

The number of staff needed for each shift was calculated based on the number of people using the service and their presenting needs. People, staff and rotas confirmed there were sufficient numbers of staff on duty. The same staff were consistently used to ensure continuity for people who used the service. Throughout our inspection, we observed a strong staff presence in the service and staff were available at all times to support people. The manager told us how they had recently reviewed the staffing levels in the home and also the shift patterns worked by staff. Staff told us the manager had simplified the shift patterns and this had made a positive impact on the well-being of staff. One member of staff told us "We have set staffing teams so we are familiar with the other staff working with us and because of the team pattern; residents are also familiar with all of the staff on shift." The people we spoke with told us they knew the staff who supported them and staff knew them well. The relatives we spoke with were happy with the staff being regular and familiar to the people living at the service.

New employees were appropriately checked through robust recruitment processes to ensure their suitability for the role. Records showed us staff had a Disclosure and Barring Service (DBS) check in place. A DBS check allows employers to see if an applicant has a police record for any convictions that may prevent them from working with vulnerable people.

People's medicines were safely managed. There were clear policies and procedures in place on the safe

handling and administration of medicines. Medication administration records (MARs) recorded people had received their medicines. Staff received training, observed other staff and completed a competency assessment, before being able to give medication. Care and support plans gave staff guidance on how people preferred to take their medication which staff followed to ensure they were meeting people's needs.

Where people had been provided with equipment to support them, we found this had been maintained appropriately. For example, where hoists were used to support with moving and handling, these had been serviced regularly to ensure they were safe to use.

Staff completed training in infection control and food hygiene. This meant the chef could prepare meals as required and understood the procedures in place for minimising the risk of infections. Staff told us they had received appropriate training in their induction and this was useful. The home employed seven housekeepers who covered the cleaning duties in the service seven days a week. We found the service was clean and free from odour.

Requires Improvement

Is the service effective?

Our findings

The service provided was not always effective in meeting the needs of the people living at Watermoor House.

We viewed the training records for staff which confirmed staff received training on a range of subjects. Training included first aid, safeguarding, medication, MCA and DolS. However, this training had not always been effective in enabling staff to support people in accordance with current good practice.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible and legally authorised under the MCA.

We could not be satisfied that the training provided to staff around the MCA was always effective in meeting their learning needs and providing staff with the skills to effectively carry out their role. Although staff always sought consent from people before delivering care, they showed a lack of understanding around the principles of the MCA. The staff we spoke with lacked confidence to assess people's level of capacity and were unclear on what a mental capacity assessment consisted of. This lack of understanding of the MCA was also evident in the support provided to people. For example, it was clear from reading people's care records that there had been deteriorating levels of capacity noted. However, staff had not given consideration to changes in people's capacity and the fact that they may no longer have capacity and would require a formal mental capacity assessment and best interest decision to be completed. One record had a comment from a member of staff on how capacity assessments were 'quite a difficult procedure.' Staff had received training but this had not been effective in embedding the principles of the MCA in practice.

No competency checks had been completed to ensure staff fully understood the principles of the MCA or learning from other training which they attended. The manager told us staff training was an area that required improvement and she was committed to improving this.

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

Staff had received training around dignity and respect and throughout our inspection we observed people being treated with kindness and respect. However, some improvement was needed to ensure the wording used in people's care plans were personalised and reflective of staff's caring approach. The provider told us that they would be working with staff to further develop their reporting skills to ensure the tone and information was consistent across the service.

Staff had completed an induction when they first started working in the home. This included reading policies and procedures, completing core training such as first aid and safeguarding and undertaking shadow shifts. These shifts allowed a new member of staff to work alongside more experienced staff so they felt more confident working with people. This also enabled them to get to know the person and the person to get to know them. Staff told us they had found the shadow shifts a "good learning experience". The manager told us new staff would also be mentored by a senior member of staff who they could approach if they had any questions or concerns. Staff told us they had found the mentoring experience to be positive and it gave them confidence there was somebody always available if they had questions during their induction.

Staff had received regular supervision. These were recorded and kept in staff files. The staff we spoke with confirmed they had received supervision from the manager. Staff told us they felt the quality of supervisions had improved significantly since the new manager started in their post. Staff working at Watermoor House received an annual appraisal.

People were supported to ensure they had sufficient food and drink. People spoke positively about the food provided at the service. One person said "It is tasty". Another person said "The food is very good and there is always enough." People told us there was always a choice of meals and if they wanted something different to what was being served; the chef would provide an alternative meal option. The relatives we spoke with told us they felt the food provided at the service was of good quality. The manager told us the menu was always under review and they had recently employed a new chef who would be meeting with people to discuss the menu and people's choices in relation to their meals. The service had a process of recording people's levels of nutritional and fluid intake. We looked at these records and found these had been completed on a daily basis and clearly recorded what people had had to eat and drink.

People's care records showed relevant health and social care professionals were involved with people's care; such as GPs, dentists, opticians, specific health professionals such as; occupational therapists and cancer specialist nurses. In each care and support plan, support needs were clearly recorded for staff to follow with regard to attending appointments and specific information for keeping healthy. One person said, "They have a lot do with the nurses and this really helps."

The building and gardens were well decorated and maintained to a good standard. There was a warm, welcoming and homely atmosphere at Watermoor House. People were supported to decorate their bedroom to individual preferences. People and their relatives confirmed they were able to choose how their rooms were decorated. Access ways had been adapted to make them accessible to wheelchair users. As the service was spread over three floors, there was a lift and stair lift to enable people to access all areas of the home.

Good

Is the service caring?

Our findings

The service provided to people was caring. People were supported by staff who were kind, compassionate and caring.

There were positive comments about the staff from people and relatives and health professionals. One person said, "The staff are caring." Another person said "The staff are very caring. They are always looking out for us." The relatives we spoke with felt staff were kind and caring.

There were many compliments evidenced in a large file with letters, emails and cards. One email from a family member stated how their mother had chosen to remain at Watermoor House on a permanent basis after a successful respite break. The family member went on to praise the staff for their kind and caring nature. Another family member stated "They are encouraged to be as independent and mobile as possible. I worked in a care home for 20 years so I have an insight into the trials and tribulations of this type of work. Watermoor stands alone in its excellence."

People were supported by a consistent team of staff. This ensured continuity and enabled people to get to know the staff who supported them. People told us the consistent staff teams were reassuring for them as they were confident they would be supported by familiar staff who knew them well. Staff commented on how they worked well as a team and were keen to support each other in their roles.

People's care records included an assessment of their needs in relation to equality and diversity. Staff we spoke with understood their role in ensuring people's needs were met in this area. All of the people we spoke with told us that staff treated them with dignity and respect, particularly when they were delivering personal care. People told us how staff would respond quickly to any concerns they have. One person said "If I use my call bell they always come quickly." Another person "They take my welfare seriously and are genuinely concerned about me. They do their best to help me." Where required, people were supported to access support from advocacy services.

The manager told us people's privacy was taken seriously and all staff were required to maintain confidentiality at all times. The manager told us how people's care records were kept on a secure computer system and a user name and password were required to access people's records. Where records were kept on paper, we saw that these were stored securely in locked drawers and offices.

The manager told us that recognising staff and what they do was important to them. The provider had implemented a monthly staff recognition scheme where staff could nominate a colleague for their dedication and hard work. The manager told us the staff member with the most nominations would receive a monetary gift from the provider in recognition of their service. We spoke with one member of staff who had been awarded the prize in the month prior to our inspection. They told us how the recognition had driven them to work harder in their daily role.

The manager told us family and friends of people living in at Watermoor House could visit at any time.

People and their relatives confirmed that there were no restrictions on visiting. One relative commented on how they could visit their family member as much as they wanted and there were never any restrictions on when they could visit.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's individual needs.

The service had an admissions assessment process to determine whether the service could meet people's needs. The manager informed us people, relatives and their representatives were provided with opportunities to discuss their care needs during their assessment prior to people moving in.. The manager also stated they used information from health and social care professionals involved in the person's care to inform their assessment.

However, the service's assessment process required improvement to ensure it would always identify people's individual needs and preferences. We found the initial assessment of people's needs was brief and did not contain person centred information about all their needs. For example, one person's assessment contained very brief information relating to areas such as personal care, continence and mobility. This had resulted in an assessment which was not always person centred. Where the service used evidence from other health and social care professionals, this was not always recorded correctly and had therefore not been incorporated into the care and support people received. For example, one person's assessment from their social worker clearly stated that they lacked mental capacity to make decisions independently. However, this information had not been reviewed by the service and the manager and all of the staff assumed this person had no difficulties with making decisions about their care. There was a risk that people would therefore not always receive the care they needed to meet their needs.

Each person had a care and support plan to record and review information about them. The service used a computer system to record and review people's care needs. The care and support plans detailed individual needs and how staff were to support people. Each care and support plan covered areas such as; safety, personality, physical health, eating and drinking, environment, family, friends and community, biography, sensory impairment and spirituality. Care and support plans gave staff guidance on how to support people. On the front page of people's care and support plans their likes, dislikes, critical care and support needs were documented. A preferred routine was available to show how people liked things to be done. One person's care and support plan stated how their personal care should be carried out, what food or drinks they liked and any other tasks that need to be completed.

However, the system to record and review people's care needs and preferences was not always effective. For example, one person had stayed at the home for three weeks but no care plan had been created for them. When looking at this person's records, it was evident there care plan had been created after they had left the home. We discussed this with the manager who told us the staff were using the manager's initial assessment to support this person. We looked at this assessment and found this was a brief document and was not person centred to the person .

For two other people, we found there had been changes in their needs in relation to their skin condition and continence. However, their care and support plans had not been reviewed or updated to reflect their changing needs for at least two months. The manager and provider told us they used documents from other

health professionals such as the continence nurse and body maps to record changes to skin conditions. However, we found people's risk assessments relating to areas such as continence or skin care had not been updated for at least two months. During our discussions with staff, it was apparent that staff had a good understanding of people's needs due to the length of time they had worked with people and the relationships they had built with people over this time. The manager told us the system used within the service prompted staff to review people's care plans and risk assessments at least once a month. However, this had not always taken place. The care records we looked at had not been reviewed or updated since November 2017. The information available to staff where therefor not always up to date to ensure they would know how to meet people's changing needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

People were supported at the end of their life to have a comfortable, dignified and pain free death. If people required end of life care, the service sought support and guidance from specialist health professionals. However, recording of end of life planning required enhancement to show discussions had been attempted with people regarding their choices and preferences in relation to end of life care where people had declined to discuss detailed plans.

People's care and support plans had recorded their communication needs. Staff were knowledgeable and supportive in assisting people to communicate with them. People were confident in the presence of staff and the staff were able to communicate well with people. Staff evidently knew people well and had built positive relationships. Family members we spoke with stated they felt the staff knew their relative's needs well and were able to respond accordingly. Information was made available to people in a format that was easy for them to understand. For example, the manager told us information could be provided in different languages or large print if required.

People were supported on a regular basis to participate in meaningful activities. There was a full time activities coordinator employed at the home. During the inspection we observed daily activities in the mornings and afternoons. When observing these, there was evidence that staff involved all the people in the communal area if they indicated a wish to participate in activities. All of the people we spoke with praised the activities coordinator for the effort they put into their role and the variety of activities on offer. Relatives we spoke with praised the activities coordinator for their enthusiasm and dedication.

There was a complaints policy in place which detailed a procedure for managing complaints. . Where complaints had been made, there was evidence that the concerns raised had been addressed. Staff told us they felt more able to raise concerns since the management changes in November 2017. One staff member said, "I didn't raise complaints prior to November as I felt there was no outcome from management but if something occurred now I would raise it."

Requires Improvement

Is the service well-led?

Our findings

The service was not always well-led.

There was no registered manager in post during our inspection as the previously registered manager had left their post in November 2017. A new manager had been recruited and had commenced employment in November 2017. They were in the process of registering with CQC to become the registered manager to support the provider to meet the requirements of their registration and had submitted their application for this. People and staff were complementary about the manager. People, their relatives and staff told us the manager was a strong leader and was approachable. Staff told us they had a good relationship with the manager and they felt listened to. One staff member said, "The manager is always around, they don't sit in the office all the time and there is a clear presence on the floor."

The manager told us they held responsibility for the day to day management of staff and people's care. The manager told us that the provider was supportive and available if any practical issues for example, relating to the premises was to arise.

Systems were in place for the provider, manager and staff to assess, monitor and mitigate risks to people's health and safety. The provider required monthly audits to be carried out in areas such as; care overview and care plans, maintenance and grounds, health and safety, medication and infection control. The manager had completed these audits in the two months prior to the inspection. However, we could not be satisfied that these audits had always been effective in driving improvements in the service. For example, we found the provider had not addressed concerns where people's care had not always been planned to meet their individual needs and when people did not always receive safe care in accordance with their policies when they fell or their health deteriorated. They had not identified when people lacked capacity to consent to their care and staff had not followed the requirements of the law to protect people's rights.

An effective system was not in place to ensure staff training, observation of their practice and supervision would always be effective to ensure staff were supporting people in line with their care plans and national best practice guidelines. A system was not in place to ensure when poor practice was identified action would be taken to address and monitor staff's performance to ensure they would provide safe care for people. For example, there was no process or competency checks to ensure staff understood the MCA and its principles following training in this area.

Staff were aware of their role in reporting and recording accidents and incidents to support the manager to monitor risks in the service. This included for example, the reporting of people's falls. However, we found the safety incident reporting system was not sufficiently comprehensive to ensure incidents would be analysed and used to review people's risk assessments to ensure further deterioration to people's health was managed. The manager was informed of safety concerns that could indicate people's health and safety were at risk. For example; the manager told us staff would tell them if they identified any concerns, they used a number of systems such as body maps and people's daily care records to record this information. However the incident reporting and reviewing system did not ensure people's risk assessments were

updated following these incidents to ensure staff had a written record of the action they needed to take.

Written accident and incident documentation did not contain enough detail including the lead up to events, what had happened and what action had been taken. There were a number of incident and accident reports for the previous six months. One person had fallen three times within one week. We saw no record of action that had been taken to address and investigate this; therefore it was unclear whether accidents and incidents were avoidable and whether there were any patterns or themes that could be used to drive improvements. There was a lack of learning from incidents and events with no analysis to establish patterns of trends. Some patterns were obvious to inspectors after assessing some incident reports but the registered manager had not picked this up and incidents continued.

A system was not in place to check whether post falls observations had been completed after each fall to identify possible injuries. The manager told us staff did not always complete these checks but could not tell us what action they had taken to ensure staff would always follow the provider's guidelines to keep people safe following a fall.

There was not an effective system to monitor the quality of peoples' care records and ensure the people's records reflected their needs and planned care. Care plans and risk assessments were in place but were not always reviewed and updated to reflect people's changing needs. When people were admitted to the service, a pre admission risk assessment was carried out and there was a checklist in place however; this was not robust enough and lacked detail. For example, one person had been assessed by their social working as lacking capacity but this had not been incorporated in how their care was to be planned and delivered to meet this need. The ineffective operation of a robust governance system to ensure records were analysed and completed accurately by staff exposed people to risks of unsafe or inappropriate care or treatment. Some other records such as those relating to staff training and records of servicing of equipment or services were not readily available when we requested these.

There were policies and procedures in place and these had all been updated and reviewed regularly. However, these were not always implemented by the manager or staff. The manager told us "Going through the falls risk assessment policy at the moment. Watermoor house has never used this policy. It has never been put into practice. This is alongside a lot of the policies we hold in the home. The falls policy has very useful information and easy to use charts to follow. I will call a staff meeting to ensure staff are aware that the home will be enforcing this policy. The provider had not ensured that the policies they had put in place were effectively implemented through robust quality monitoring. This would ensure staff would provide care in accordance with current best practice and would be able to identify when people were not received care in line with current quality and safety standards and might be at risk of harm. This was evident in staff not implementing the provider's falls and mental capacity policies appropriately.

The failure to provide good governance to ensure the safety and quality of service provision is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The culture of the home was one of uncertainty and in a transitional phase due to many changes taking place. The manager told us systems and processes required updating but she was committed to improving areas of the service. Staff told us, "There has been quite a lot of change but (new manager) is doing her best to turn things around. She is approachable and always willing to listen. This has helped with the morale amongst the staff." These feelings were shared by all of the staff we spoke with.

Regular resident and staff team meetings were held and records kept. Staff told us they found these meetings useful. We saw from the minutes of the meetings that staff were encouraged to express their views

and opinions and any concerns or issues raised were responded to. The provider and manager had consulted with staff and introduced a new shift pattern and rota which was working well. Team meeting minutes showed us this had been discussed and staff were happy with the new rotas.

The manager was working in partnership with the local authority to improve areas of the service. The local authority had carried out an annual review of the service four days before our inspection. The overall tone of this report was positive but had identified some recommendations. The manager told us they were currently looking at the review's report and they were going to book staff on new training courses as recommended by the local authority review.

The service was actively seeking the views of people, their relatives and the staff through sending out questionnaires and having regular meetings. The provider and manager told us this was a way of ensuring everyone involved with the service had a voice. The provider and manager told us they were in the process of analysing the feedback from the surveys and this was due to be completed by the end of February 2018. The manager told us this would result in an action plan to drive improvement within the service.

From looking at the accident and incident reports, we found the manager was reporting to CQC appropriately. The provider has a legal duty to report certain events that affect the well-being of the person or affects the whole service.

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 9 HSCA RA Regulations 2014 Person-centred care People's care had not always been planned to meet their individual needs. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There had been a failure to assess, monitor and improve the quality and safety of the service. 17 (2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not always developed the skills and knowledge they required to undertake their roles through the training and supervision they received. Regulation 18(2)(a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments relating to the health, safety and welfare of people using the service were not completed or reviewed regularly. 12 (2)(a)

The enforcement action we took:

We have issued a warning notice requiring the provider to become compliant in 2 months.