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	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 2 and 3 November 2016. This was an unannounced inspection. The service was last inspected in August 2013. There were no breaches of regulations at that time.

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 residential care home and is registered to provide support for up to 39 people. Nursing care and support is provided by district nurses and local GP's as required. Several people at Watermoor House were living with the first stages of dementia. There were 33 people at Watermoor House at the time of the inspection.

There was a registered manager in post at Watermoor House. 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.'

Our inspection highlighted shortfalls where a number of regulations were not met and improvements were required.

People did not always receive a service that was safe. Although staffing levels appeared to be safe, staff informed us there was an increased use of agency staff who did not always know the needs of people living at Watermoor House. Risk assessments were not adequate and did not contain sufficient levels of information to enable staff to provide safe care and treatment. Staff demonstrated a good understanding of safeguarding and felt confident to report any concerns to management or external agencies. Staff had been trained in the safe administration, recording and storage of medicines. Recruitment practices at Watermoor House were safe and ensured suitable people were employed at the home.

People were not always receiving effective care and support. Staff felt the training being provided was not effective and was not meeting their learning needs. Although care records stated whether people had mental capacity or not, there were no records of people's level of capacity being assessed under the Mental Capacity Act 2005 (MCA). People's nutritional needs were not always recorded and care files contained contradictory information around this. People's personal living areas were personalised. Staff received regular supervision or appraisals.

The service was caring. The majority of people and their relatives spoke positively about the staff at the home. Staff demonstrated a good understanding of respect and dignity and were observed providing care which maintained people's dignity. People had end of life care plans which clearly reflected their wishes and preferences.

The service was not always responsive. People's care plans were not person centred and did not provide sufficient detail to enable staff to provide safe care and treatment to people. Daily notes were not always sufficiently detailed to provide a clear overview of a person's day. Complaints had been dealt with but people said they were not always satisfied with the outcome of their complaint. There was an activities co-ordinator and people had a number of different activities available to them.

The service was not always well-led. The majority of the staff we spoke with stated communication between management and the staff was poor and this had resulted in low staff morale across the majority of the staff group. There were no quality assurance checks and audits being completed at Watermoor House. The registered manager had failed to inform the Care Quality Commission of significant incidents such as falls or deaths which had occurred at the home.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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

People did not always receive a service that was safe.

Although staffing levels appeared to be safe, staff informed us there was an increased use of agency staff who did not always know the needs of people living at Watermoor House.

Risk assessments were not adequate and did not contain sufficient levels of information to enable staff to provide safe care and treatment.

Staff demonstrated a good understanding of safeguarding and felt confident to report any concerns to management or external agencies.

Staff had been trained in the safe administration, recording and storage of medicines.

Recruitment practices at Watermoor House were safe and ensured suitable people were employed at the home.

Is the service effective?

Inadequate

People were not always receiving effective care and support.

Staff felt the training being provided was not effective and was not meeting their learning needs.

There were no records of people's level of capacity being assessed under the Mental Capacity Act 2005 (MCA).

People's nutritional needs were not always recorded.

People's living areas were personalised.

Staff received regular supervision or appraisals.

Is the service caring?

Good

The service was caring.

The majority of people and their relatives spoke positively about

the staff at the home.

Staff demonstrated a good understanding of respect and dignity and were observed providing care which maintained people's dignity.

People had end of life care plans which reflected their wishes and preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were not person centred and did not provide sufficient detail to enable staff to provide safe care and treatment to people.

Daily notes were not always sufficiently detailed to provide a clear overview of a person's day.

Complaints had been dealt with but people said they were not always satisfied with the outcome of their complaint.

People had a number of different activities available to them.

Is the service well-led?

Inadequate

The service was not always well-led.

Staff informed us communication between management and the staff was poor and this had resulted in low staff morale across the majority of the staff group.

There were no quality assurance checks and audits being completed at Watermoor House.

The registered manager had failed to inform the Care Quality Commission of significant incidents such as falls or deaths which had occurred at the home.

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.

This was an unannounced inspection which was completed on 2 and 3 November 2016. The inspection was conducted by one adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The previous inspection took place in August 2013; there were no breaches of regulation at that time.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they planned to make. We used this information to assist with our inspection.

We contacted five health and social care professionals to obtain their views on the service and how it was being managed. This included professionals from the local authority and the GP practice. We have incorporated this feedback into our report.

During the inspection we looked at 10 people's records and those relating to the running of the home. This included staffing rotas, policies and procedures, quality checks that had been completed, supervision and training information for staff.

We spoke with 13 people who lived at Watermoor House, five relatives, ten members of staff and the registered manager. We made general observations throughout the communal areas and dining rooms. We visited several of the bedrooms with permission from the people living at the home. We observed staff providing care and support throughout the day and how they interacted with people and also each other.

Requires Improvement

Is the service safe?

Our findings

Risks to the health and safety of people living at Watermoor House had not always been assessed or reviewed. Risk assessments were incorporated into care plans but these did not contain sufficient information to fully detail the risk to people.

For example, one person was assessed as being at high risk of developing pressure sores. Although this was identified in their care plan there were no clear instructions for staff to follow. Their risk assessment contained comments such as, 'Staff to use appropriate repositioning schedules,' but did not contain any specific detail as to what the repositioning schedule actually was. Another person who was at risk of pressure sores had similar comments instructing staff to manage the moisture contact with this person's skin using an appropriate hygiene regime. However, the risk assessment did not provide any details regarding the regime which needed to be followed. Another person was identified as being at high risk of malnutrition but there were no specific risk assessments or guidelines around this.

The majority of staff we spoke with told us they felt the risk assessments did not contain sufficient levels of detail. We received mixed feedback from the relatives we spoke with. One relative told us how their parent had specific dietary requirements and there were occasions these dietary requirements were not always met, placing their parent at risk. When looking at this person's care files, their risk assessment identified that they had a specialist diet but there was no information around what the diet was.

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

It was evident from speaking with a number of people living at Watermoor House that agency staff were used to cover staff shortages. The staff we spoke with also confirmed the use of agency staff due to staff shortages. Some people told us they felt this had compromised their care needs being met. A number of staff told us they felt the use of agency staff had a negative impact on the provision of individual and personalised care, as agency staff did not always know the needs of the people they were supporting.

We recommend the provider reviews its systems to ensure all staff are aware of people's needs and provide personalised and safe care.

We asked people at Watermoor House whether they felt safe when being helped by staff and were they ever afraid of the staff. All the residents said they felt safe and well looked after. One person said, "Everything is alright, no problems here". Another person said, "My key worker is very good. He is like a friend". Professionals we spoke with informed us they felt people were safe at Watermoor House. We received mixed feedback from relatives. Although the majority of people felt their loved one was safe at Watermoor House, others felt the safety of people living at Watermoor House had been compromised on occasion. One relative told us they felt their loved one was not always safe as they were not confident all staff knew the needs of people well and this compromised their care.

Medicine policies and procedures were in place to ensure they were managed safely. Staff had been trained in the safe handling, administration and disposal of medicines and their competency was updated annually to ensure they were aware of their responsibilities and understood their role. Clear records of medicines entering and leaving the home were maintained.

The registered manager understood their responsibility to ensure suitable staff were employed. We looked at the recruitment records of a sample of staff employed at the home. Recruitment records contained the relevant checks including a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check whether the applicant has any past convictions that may prevent them from working with vulnerable people. References were obtained from previous employers as part of the process to ensure staff were suitable and of good character. The registered manager informed us how each member of staff had a recruitment checklist in their file to ensure all of the relevant documents had been seen prior to the person commencing their role.

The service had a staff disciplinary procedure in place. This shows the service had the relevant procedures in place to manage disciplinary issues with staff to ensure people using the service were kept safe.

The provider had implemented safeguarding procedures. Staff were aware of their roles and responsibilities when identifying and raising concerns. The staff felt confident to report concerns to the registered manager or team leaders. Safeguarding procedures for staff to follow with contact information for the local authority safeguarding teams was available.

Health and safety checks were carried out regularly. We observed staff wearing gloves and aprons when supporting people with their care. Environmental risk assessments had been completed, so any hazards were identified and the risk to people was either removed or reduced. Checks were completed on the environment by external contractors such as, with the fire system. Certificates of these checks were kept. Fire equipment had been checked at the appropriate intervals and staff had completed both fire training and fire evacuation (drills). There were policies and procedures in the event of an emergency and fire evacuation. Each person had an individual evacuation plan to ensure their needs were recorded and could be met in emergencies.

The premises were clean and tidy and free from odour. The registered manager informed us housekeepers were employed who covered cleaning duties at the home 7 days per week. Staff were observed washing their hands at frequent intervals. There was a sufficient stock of gloves, aprons and hand gel to reduce the risks of cross infection. Staff had completed training in this area. The staff we spoke with demonstrated a good understanding of infection control procedures. For example, different mops were used for different cleaning activities and all cleaning chemicals were kept in a locked room to minimise the risk of people coming into contact with them. The relatives we spoke with told us the home was clean.

Inadequate

Is the service effective?

Our findings

We could not be satisfied people were always receiving effective care and support.

Training records showed staff had received training in core areas such as safeguarding adults, person centred care, health and safety, first aid, food hygiene and fire safety. Training was targeted around people's presenting conditions such as, stroke awareness and dementia training. The registered manager informed us the majority of training provided to staff was through distance learning using an external training provider. This is training which staff complete through studying workbooks and completing competency assessments at the end of each module.

A large number of the staff we spoke with told us they did not find the training to be beneficial in enabling them to provide effective care to people. They felt an increase in face to face training would be more constructive to their learning. One member of staff stated, "Training is mainly a tick box exercise to show we have done it". One member of staff commented how they felt the training provided was 'useless '.

We recommend the provider reviews its training programme and approach to determining the effectiveness of training.

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 to 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 are called the Deprivation of Liberty Safeguards (DoLS).

We could not be satisfied the service was working within the principles of the MCA. Care plans identified people as either having or lacking the mental capacity to make a particular decision. However, we could not find any documentation evidencing the MCA assessments had taken place. When we discussed this with the registered manager, they confirmed there were no MCA assessments to evidence people's capacity had been assessed before a decision had been made regarding their level of capacity. This also meant that if people required a DoLS this would not be possible as no MCA assessment had been completed.

There were a number of people who were described by the registered manager as having more complex needs. These people lived in a secure wing of the home which could only be entered or exited via a key code. Although people had access to a garden, they could not leave the wing unless they exited using a key code or walked through through the garden and grounds to the front door. The registered manager informed us all of the people had the mental capacity to make the decision to live in this section of the home. However, there was no evidence of any mental capacity assessments having taken place to determine whether these people were able to make this decision. Subsequently, there was no clear documentation around whether any of these people were being deprived of their liberty and required a DoLS application to be made on their

behalf.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

We could not be satisfied the nutritional needs of people had always been accurately recorded. Although care records included information about any special arrangements for meal times and dietary needs, this was not always consistent and in some cases care files contradicted themselves. We also saw examples where people's nutritional needs had not been recorded. In some people's care files it was noted that they had special dietary requirements but these were not always recorded. This meant there were no clear guidelines or information for staff as to what people's nutritional requirements were. For example, one person's care file identified them as being at medium risk of malnutrition in their care needs summary. However, later on in the same care file, this person was stated to be at low risk of malnutrition. Another person was identified as being at high risk of malnutrition but their care file did not contain any care plans to address these nutritional needs. Another person's nutritional care plan stated they had special dietary requirements but did not say what these requirements were.

There were a number of people living at Watermoor House whose weight needed to be monitored on a monthly basis due to their risk of malnutrition. We could not be confident this was being done for everyone living at Watermoor House. We saw a number of care files where people's weight had not been monitored as it should have for a number of months in the past year. This meant there was no clear information for staff around how people's nutritional intake was affecting them.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

We received mixed feedback regarding the quality of meals being provided at Watermoor House. Some people informed us they felt the meals were of good quality using comments such as, "It is very good" and, "The food is good". A number of people told us they felt the meals were not of a good quality. One person said, "I don't always like the food I don't eat much". Another person told us they felt their dietary needs were not always met. The registered manager had identified this and was using resident meetings to discuss the menu with the people living at Watermoor House to develop a menu which was preferred by people. The registered manager told us this was a continuous process and the menu would be changed every two months based on feedback received from people during the resident meetings.

We observed positive interactions between people and staff. One person was being assisted with their meal by a staff member who provided this support in a kind and caring way. They took their time and did not rush the person. There was lots of conversation between the staff and people during lunch.

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 that they felt more confident working with people. This also enabled the member of staff to get to know the person and the person to get to know them. Staff informed us they had found the shadow shifts a 'good learning experience'. The registered 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 informed 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 registered manager, deputy manager or senior carers. Staff who provided supervision had received the appropriate training around this. There was evidence staff received annual appraisals.

People had access to a GP, dentist and other health professionals. The outcomes from these appointments were recorded. One GP told us staff listened to advice and implemented any suggested actions quickly.

The building and gardens were well decorated and maintained to a good standard. Each bedroom was decorated to individual preferences and the manager informed us people had choice as to how they wanted to decorate their room. People and their relatives confirmed they were able to choose how their rooms were decorated.

Good

Is the service caring?

Our findings

People who lived at Watermoor House told us they were well cared for. Comments included, "Staff have been very good to me" and, "They try and help you as much as they can". One person told us how staff would bake them a cake on their birthday. They said, "You have a special cake made on your birthday and a special tea". Some relatives spoke positively about the care provided.

Staff treated people with understanding, kindness and respect and dignity. For example, staff were observed providing personal care behind closed bedroom or bathroom doors. They supported people at their own pace explaining what they were doing. Staff were observed knocking and waiting for permission before entering a person's bedroom.

There was a genuine sense of fondness and respect between staff and people using the service. We saw people laughing and joking with staff. People using the service told us they felt the staff were caring. Relatives we spoke to informed us they felt the staff were caring. People used statements such as, "The staff are caring" and, "They (staff) are very good".

People were given the information and explanations they needed, at the time they needed them. We heard staff clearly explaining and asking permission before they assisted people. 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 were observed using touch as a form of communication and to put people at ease when speaking to them. 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.

Care records contained the information staff needed about people's significant relationships including maintaining contact with family. Relatives told us they were able to visit when they wanted to. One relative confirmed there were never any restrictions on visiting times.

The service was providing end of life care. People's needs and preferences regarding this had been clearly recorded in their care files. People's end of life care plans reflected where they wanted to spend their final moments, their funeral arrangements, what they wanted to do with their possessions and any other wishes. . For example, one person did not want their body to be donated to science after their death and this was clearly recorded in their end of life care plan. People had 'Do Not Attempt Resuscitation' (DNAR) orders in place and these were clearly visible in the care files.

Requires Improvement

Is the service responsive?

Our findings

Each person had a care plan and a structure to record and review information. However, these care plans were not person centred nor did they contain sufficient information for staff to provide person centred care to people.

For example, the majority of the personal care plans we saw did not contain any information from people receiving the support as to how they wanted their personal care to be provided. One person required support with mobility and transfers, their care plan advised staff to use 'suitable aids' but did not go on to say what mobility aids this person required or, what actual support they needed with their mobility. This type of recording was consistent across the majority of the care plans that we looked at. It appeared to us from reading the care plans that a lot of the information had not been personalised for each person. For example, most people's mobility care plans, pressure sore management care plans and personal care plans were identical with only the name being changed.

It was also evident from reading the care plans that they had not been read for accuracy and we observed a number of care plans which contained contradictory information For example, one person was assessed as having no memory difficulties at the start of their dementia care plan. However, this person was then noted as having short term memory loss later in the same care plan. Another person's care needs summary contained contradictory information in relation to their nutritional needs.

The majority of staff members we spoke with told us the care plans did not contain sufficient information about people's needs and they did not have enough time to read care plans. Staff members informed us they could only provide a satisfactory level of care due to the length of time they had known people.

Daily notes did not contain sufficient detail to provide an accurate description of what a person had been doing during the day. We looked at the daily records of 14 people living at Watermoor House and only three of these contained sufficient detail to show what a person had been doing during the day. For example, one person had a recording to say they had a drink at 7:00am. The next recording stated they had lunch in the dining room. There were no other details of what the person had eaten or what activities they had engaged in during the day. This demonstrated a lack of understanding from staff in relation to person centred care or good record keeping.

The registered manager informed us people and their representatives were provided with opportunities to discuss their care needs when they were planning their care and, their care needs were being reviewed. When looking at the care files, although there was evidence of reviews taking place, these did not contain any information regarding the input from people living at Watermoor House, their relatives or other professionals who were involved in their care.
We received mixed feedback from relatives in relation to their involvement with care reviews. Some relatives we spoke with informed us they were consulted in the care reviews of their loved ones. Other relatives informed us reviews had taken place but they had not been consulted regarding the needs of their loved ones.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

There was a complaints policy in place which detailed a procedure for managing complaints. Where complaints had been made, there was evidence these had been addressed. However, we did receive mixed feedback on how complaints were managed by the registered manager and people informed us that it could take months before something was resolved. One person informed us it had taken over three months to resolve a complaint they had raised with management.

We recommend the provider reviews how complaints are managed and ensure they are dealt with in a timely manner.

Reports and guidance had been produced to ensure unforeseen incidents affecting people would be well responded to. For example, if a person required an emergency admission to hospital, care staff would use the 'Key information' document in the care file to send to the hospital with the person. This contained basic contact details, medication and daily needs. When speaking with staff, they were clear as to what documents and information needed to be shared with hospital staff.

People we spoke with informed us they had 'resident' meetings approximately every two months. This was confirmed by the registered manager. People told us they felt these meetings were 'good' as it allowed them to express their views in relation to the running of the service. A number of people told us how the menu was a regular agenda in these meetings and they felt that their opinions were taken into account when developing future menus following these meetings. For example, during one meeting people had requested the tuna pasta bake to be reintroduced to the menu and this was implemented from the following week.

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 staff involved all the people in the communal area if they indicated a preference to participate in activities. Relatives we spoke with informed us they felt there were enough activities.

Inadequate

Is the service well-led?

Our findings

The service was not well-led.

There were no quality assurance systems in place at Watermoor House. For example, there were no audits taking place to assess the quality of the care being provided to people. This meant the registered manager or provider did not have a method of assessing the quality of the service being provided to people. For example, when we spoke with the registered manager regarding the audit processes at the home they informed us there were no records of audits taking place but, informed us they completed regular audits of the care files which were not recorded. However, due to the poor quality of the care files, we could not be satisfied these audits were effective enough to identify common issues we found across all of the care files. The registered manager informed us they were planning on introducing written audit records over the coming months.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

From looking at the accident and incident reports, we found the registered manager was not reporting to us appropriately. The provider, and or registered manager has a legal duty to report certain events that affect the well-being of the person or affects the whole service.

One person had suffered a serious injury four days before the inspection but we had not received a notification regarding this. The registered manager reassured us the notification would be sent to CQC. Although we received this information five weeks after our inspection, the provider and registered manager were unable to provide any evidence that these notifications had been sent in at the time when these incidents had taken place.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.

There was no clarity over how many people had passed away whilst living at Watermoor House. A number of staff we spoke with informed us four people had passed away over the past 12 months. However, when we spoke with the registered manager they informed us only one person had passed away over the past 12 months but they were unsure of this. They informed us they would check their records and provide this information to us. Although we received information relating to the number of deaths at Watermoor House over the past 18 months, the provider and registered manager were unable to provide any evidence that these notifications had been sent in at the time when the deaths had occurred.

This was a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009. Notification of death of service user.

Staff did not always feel that their views were sought or valued. There was a strong sense that the culture of

the service was not always open and transparent. The majority of staff we spoke with told us they felt communication between the management and staff was poor and this had resulted in low morale amongst the staff. Staff told us they would not always be informed of changes to the administration team which resulted in staff questioning what roles people had in the home. Staff also informed us they were not always told when new people would be moving to the home. Staff said there were many occasions when people moved to Watermoor House and staff were not made aware of this and the needs of the person were not discussed with the staff who would be supporting them. Staff told us they felt that as a result of this they were not able to provide a good level of care to people.

During our visit we saw the registered manager spending time with people living in the home offering drinks and giving other offers of support. However, some of the people living at Watermoor House, a number staff and some relatives informed us this was generally not the case and the registered manager was predominantly in their office on a day to day basis. It was evident from the comments made by staff they would benefit from increased management presence around the home. This would help staff appreciate what is expected of them, ensure they are happy in their work, are motivated and have confidence in the way the service is managed. The management structure should be consistent, led by example and be available to staff for guidance and support.

Staff told us team meetings took place but there was no clear timetabling of these and were not always regular. Staff said this meant they could not always make themselves available for meetings or prepare in advance as they were never certain when the next meeting would be taking place. Staff told us they felt management would not always listen to them and act on their concerns. Staff informed us of an incident where they raised concerns regarding the suitability of Watermoor House for a person who's needs had significantly increased. Staff told us they had informed the registered manager they could no longer manage this person's needs as they required a specialist home. The staff said they were not listened to and this person remained at Watermoor House despite the struggles of the staff to meet this person's needs.

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 Care plans were not person centred and did not contain sufficient detail. Regulation 9(1). People, their families and relevant professionals were not involved in reviewing and updating their care records. Regulation 9 (3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments did not contain sufficient information or guidance for staff. Regulation 12 (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 16 Registration Regulations 2009 Notification of death of a person who uses services The registered manager had failed to notify the Care Quality Commission when people living at Watermoor House had died. Regulation 16 (1)

The enforcement action we took:

We have issued a warning notice to the provider and registered manager requiring them to become compliant with this regulation within 3 months.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager had failed to notify the Care Quality Commission when a person had suffered a serious injury. Regulation 18 (2)(a)

The enforcement action we took:

We have issued a warning notice to the provider and registered manager requiring them to become compliant with this regulation within 3 months.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People had deemed to be having or lacking capacity but there were no mental capacity assessments documented. Regulation 11(1)

The enforcement action we took:

We have issued a warning notice to the provider and registered manager requiring them to become compliant with this regulation within 3 months.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were no records of audits being completed. Regulation 17 (2)

The nutritional needs of people had not always been accurately recorded. Regulation 17 (2) (c)

The enforcement action we took:

We have issued a warning notice to the provider and registered manager requiring them to become compliant with this regulation within 3 months.