Daughters of Mary Mother of Mercy

Waverley Care Home

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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This unannounced, comprehensive inspection took place on 19 and 20 August 2015 and was conducted following receipt of information of concern. The service was registered to provide care to people who may have nursing needs. The service was registered to provide accommodation for 20 people, there were 11 people living at Waverley Care Home at the time.

Waverley Care Home is located in a period property near to Sefton Park Liverpool and is close to local amenities such as cafes, restaurants, shops and public transport links. There is on street parking and a garden to the rear of the property. The service provides care over three floors.

The home required a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

Prior to the inspection three whistle blowers contacted CQC and raised a number of concerns about the home and the practices in it. They included medication issues

Summary of findings

pertaining to a particular member of staff and staffing levels. We looked into the concerns raised and found them to be unfounded, however other concerns raised were substantiated.

We found breaches of The Health and Social Care Act 2008 relating to safe premises, the administration of medication, consent and capacity and how the home was managed. You can see what action we told the provider to take at the back of the report.

We saw that the safety of the premises and equipment which was being used put people using the service, staff and visitors at risk. We made referrals to the local authority infection control department and the fire service.

We found a number of breaches related to medicines management and made a referral to the local authority medicines management team. Medicines were not always managed safely because the administration recording sheets did not always record the number of tablets administered. We also found that some medication was not accounted for.

Concerns had also been raised with us in relation to the application of the Mental Capacity Act.

We found that correct consideration had not been given to support people under the Mental Capacity Act 2005 (MCA). We did not see any documentation confirming if people using the service had capacity to consent.

We found breaches of The Health and Social Care Act 2008, regarding good governance in the service, the home is without a registered manager and we had a number of concerns about the lack of quality assurance processes in the home to monitor the service provision.

We found that not all areas of the home were free from odours. In relation to orientation we found that there was little signage around the service to identify different areas, especially to support people living with dementia.

The staff in the home knew the people they were supporting and the care they needed and a wide range of activities were available to suit the varied interests of the people using the service.

The care plans that we reviewed showed that preadmission assessments had been conducted and

people's individual preferences were recorded in their care files.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

We found that the service was not always safe and have made referrals to the relevant bodies.

Staff were recruited safely and knew how to recognise and report abuse

Requires improvement

Is the service effective?
The service was not always effective.

We found that that the provider had not kept up to date with the guidance on

The Mental Capacity Act and consent.

We found that the environment would benefit from improved design and orientation to support people with dementia.

Requires improvement

Is the service caring?
The service was not always caring.

The care plans recorded that the health and social needs of the people using the service were met.

We found that the privacy and dignity of people using the service was not always maintained.

Requires improvement

Is the service responsive?
The service was not always responsive.

People's individual needs and preferences were documented.

We found that complaints and concerns were not always documented.

Requires improvement

Is the service well-led?
The service was not well led.

There was no registered manager in post and there were mixed comments from people using the service, staff and visitors in relation to the management of the service.

We found that audits and monitoring of the service needed improvement in order to maintain safety and improve the service.

Requires improvement

Waverley Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 inspection took place on 19 and 20 August 2015 and was unannounced. The inspection team consisted of a lead Adult Social Care (ASC) inspector and two other ASC inspectors. This comprehensive inspection was conducted following receipt of information of concern. Because of this we had not asked the provider to complete a Provider Information Return (PIR), which is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we had on the service including concerns that had been raised with us. They included end of life care, medication issue for a member of staff, Deprivation of Liberty and application of the Mental Capacity Act, management of the home, staffing levels, suitability of food and the knowledge of senior members of staff in relation to safeguarding. We also reviewed information from the Local Authority and notifications sent to us by the provider. Following the inspection we asked the provider to send us further information relating to work permits for three members of staff and submission of a notification which they did so in a timely manner.

We spoke with six people who used the service and one visitor. We also spoke with seven members of staff including carers, nurses and ancillary staff. We looked at seven care files, four staff recruitment files and other documentation relating to staff training and supervision. We reviewed audit files and other records relevant to the running of the service and carried out pathway tracking to establish if what was stated in the provider's policies was put into practice and if the care provided to people using the service was as it had been planned.

We observed and chatted to people using the service and staff throughout the inspection and observed the maintenance of the building.

Requires improvement

Is the service safe?

Our findings

We spoke with people who lived in the home and two of them when asked told us that they felt safe living in the home. However another person told us "The bars on the windows to keep us in, not people out…".

One staff member told l us, ‘‘If there's anything I can't keep silent it's their safety and security. I know about safeguarding and how to report it". Another told us, "I did my safeguarding training in May".

Prior to the inspection three whistle blowers contacted CQC and raised a number of concerns about the home and the practices in it. They included medication issues pertaining to a particular member of staff and staffing levels. We looked into the concerns raised and could not substantiate them.

We were shown a list of people who lived in the home which was dated March 2015. This was inaccurate at the time of our inspection because it showed 13 people living in the home when there were actually only 11. There were very brief notes by the side of each name to describe that person’s mobility in case of emergency. This record, even in its incorrect state, was not available in a centralised and accessible place as it was on a noticeboard in an office situated on the basement floor of the building. This also meant that if an emergency evacuation of the premises was needed the rescue services may be put at risk looking for people who did not live at the service.

During the inspection we walked around the building to look at the safety of the premises. We found that the evidence we saw did not confirm that all aspects of the service were safe, some areas of the building were in need of attention for decoration and repairs and some posed infection control or electrical safety concerns.

In the garden there was litter scattered on the ground including personal protection equipment such as aprons, some kitchen towels and other rubbish. There was a fire escape leading from the garden to the floors of the house, which looked rusty and potentially unsafe. There was no secure access to the fire escape from the garden, which meant people might try to go up the steps which were steep and potentially unsafe. The smoking area was situated underneath the fire escape, with a table and chair and waste bin full of flammable material. There was no ashtray, which meant that there was no safe way for people to extinguish their cigarettes and posed a potential fire risk.

The access to the front of the home was by steep steps. There was a sloping pedestrian/wheelchair access at the back of the building but we found that this was in a state of disrepair and posed a trip hazard.

We saw that the consumer unit and an associated electrical box which was situated on a wall in a corridor, was unsecured and accessible. It was very easy for a person of moderate height to open the box which would show exposed wires within it as the correct closing mechanism was broken and it was secured only by sellotape. We were concerned about the risks that this posed and arranged with the provider for this to be repaired on the same day by a qualified electrician.

The older windows in the building had window restrictors. However, the newer UPVC window had none. This meant that people would have been able to access the wide-open windows at any time which was a falls risk. One of the windows, we noted, had no handle at all on it. We discussed this with the manager who took action to arrange for a maintenance person to visit and address the problem.

On the ground floor we looked in a bathroom that had what appeared to be an electric bath in it. Over this bath was an electric seat hoist. The controls to the bath were connected because we heard the motor, but the bath did not operate. The hoist did work but we didn't see any evidence that it had been recently serviced. We saw a loose green and yellow wire coming from the bath and looping to the central heating system.

We found in one bedroom what appeared to be cigarette burns on the carpet. There was an ashtray which was empty on the bedside locker but it looked as though it had contained ash. The room smelt slightly of cigarette smoke. We asked the occupant if they had ever smoked in their room and they told us, "The government doesn't allow it I think it's right because of fires". However, a member of staff told us that they knew another resident did occasionally smoke in their room. In another bedroom the plastic commode basin had what appeared to be cigarette burns on it. The staff member who accompanied us around the home told us that the marks were rust marks.

Requires improvement

Is the service safe?

We found that risk assessments were in place to support people who smoked, however we remained concerned about the general risks of fire in the building and have made a referral to the fire safety officer for the area.

These findings demonstrated that the provider had not ensured that the premises were safe for the people living in the home.

These were breaches of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at systems and practice in relation to medications within the service and found that there were areas of unsafe practice.

We saw that peoples care files contained medication lists in that showed the drugs and the quantities and times that they were supposed to be given. However, on reviewing the medication administration record sheets (MARS) we found that the number of tablets administered was not always recorded. We discussed this with the nurse in charge who told us that there was no room on the record to do so. This meant that staff were unable to determine what dosage had been administered over a 24 hour period. This put people using the service at risk of being in pain or of receiving an overdose of medication.

We also found that the stock balance record for an addictive drug was incorrect and some tablets could not be accounted for. Records were not readily available to check how many had been administered to the individual they were prescribed for.

Medication audits had not been completed regularly and when they had issues were not identified.

We referred our concerns to the local authority medicines management team.

This example is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence in the home that suggested the management of infection control could be improved. For example the bathroom on the top floor was in need of redecoration and did not appear to have been recently cleaned. There was no soap in the dispenser and therefore this posed an infection control hazard as people were not able to correctly wash their hands after using the toilet.

The bathroom on the middle floor had no hot water from the hand basin tap. The ground floor bathroom had a pedestal bin and the foot pedal did not operate the lid properly meaning that it had to be opened manually and posed an infection control hazard. We found in one bedroom the sink was blocked and therefore could not be used.

We referred our concerns to the local authority infection control team.

There were sufficient staff on duty at any one time, we saw from both the rotas and from the shift that we saw on the day of our visit.

Staff told us they'd received safeguarding training and were able to tell us about safeguarding and how to report it. However not all senior members of staff were fully aware of the need to contact CQC in relation to an allegation of abuse. We saw that there was information about how to contact Careline (which was the local point of contact for social care) on notice boards but the policy relating to safeguarding was not available other than in the office.

The five staff we spoke with told us how they'd been recruited. All said that they filled in an application form had had an interview where notes were taken and their role had been discussed with them. This was confirmed when we looked at the files and found that there were safe and effective recruitment procedures in place. There was some missing information in three files but the manager was able to produce this following the inspection

This meant that the risk in employing people who were not suitable to support vulnerable people was minimised.

Requires improvement

Is the service effective?

Our findings

We asked people if they liked living in the home. One person said “Yes I like living here. The food is nice, I like curry rice and chips and coffee.” Another person told us about the food, “Oh, yes, we get a choice”. One person In relation to leaving the building told us ‘’It's like the front door with the keypad; I don't know the number".

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people’s best interests. The Deprivation of Liberty Safeguards (DoLS) is part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

We saw in a file that there was a lot of information about mental capacity and deprivation of liberties, such as the Liverpool Council and Liverpool community NHS trust document and the actual Mental Capacity Act 2005 with the appendices.

The training matrix showed that only five staff had completed Mental capacity and DoLS training

We spoke with staff, including senior staff, but they were not able to accurately describe what the Mental Capacity Act and DoLS meant. We were told that there had been DoLS applications for four people one of whom had now left the service. We saw in the care files that a further six people had applications made for DoLS in relation to their personal care needs. We discussed the need to ensure that everybody in the home had a mental capacity assessment who required one. Applications should have been made for those people who did not have the capacity to understand the risks of leaving the home. This was in relation to the potential deprivation of liberty because people were prevented from leaving the home as they did not have the keypad access code.

We reaffirmed this in a meeting with senior members of the organisation in a meeting following the inspection.

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

We spoke with staff about training. One person told us "No experience is lost. I've always updated my training". Another told us, "Training is mapped out for us, some of it is outside training and some is e-learning, which is good".

One member of staff told us that they had been encouraged to take further qualifications in order to improve their knowledge. Another told us that they have been able to achieve NVQ five (management related) but preferred to stay in their current position. Staff told us that they had completed safeguarding training, Mental Capacity Act and Deprivation of Liberty Safeguards training and food hygiene training as well as health and safety and moving and handling training. Some staff had had more specialist training in for example, dementia and diabetes.

However this information could not be reconciled with records. We looked at the training matrix that showed there were 19 staff employed by the organisation.

All staff had completed online training for health and safety, safeguarding, infection control, and fire safety. Only 11 staff had completed bed rail training, 13 moving and handling training and no one had completed food hygiene, or first aid. This meant that we were unable to determine if all staff were fully trained to meet the needs of people living at the service and if they were putting themselves and others at risk.

Staff told us that they had had some supervision meetings with their manager. However all forms were dated to have taken place on the same day and one for one person the date was before they had been employed by the provider. A supervision is intended to include identified issues for the individual member of staff, focus on what is going well and identify areas for improvement including training needs.

We saw that the environmental layout of the home was not dementia friendly in parts and signage was inadequate. For example there were no signs of orientation or direction to communal areas or bedrooms to assist people in their orientation and to help maintain their independence.

We noticed that several areas were in poor decorative condition and had a bad odour. We were told by a staff member that the problem regarding smell was with the carpets. They said, "They are due to be replaced but not yet. It needs to be done". In a bedroom we saw that the decor was in poor condition with wallpaper hanging from the wall near the ceiling.

Requires improvement

Is the service effective?

We saw that the appropriate measures had been taken to ensure that people had adequate hydration and nutrition and that the risks relating to pressure areas had been addressed.

The dining room was clean and bright, the tables were nicely set and there was sufficient crockery and tables/trays for everyone.

There was a menu available to the people in the home which we saw. We found however that on the days when there was a roast dinner available, there was no other choice noted on the menu whereas on the other days an alternative to the main was written down. We asked the cook whether other options were available to people who didn't want what was on the menu and were told that alternatives would be provided.

When we asked about people's personal preferences, choices or dietary needs, we were told that the cook remembered what people wanted or needed and that they were written down in the daybook. We looked in the book and found a few references to people's dietary needs. These notes were scattered throughout the book and difficult to find. We were told that there were more needs than recorded in the book. This meant that some people's choices and dietary needs were not recorded and accessible to any relief staff.

We sampled the food at lunchtime which was roast beef with the accompanying vegetables and found it hot and tasty. There were two puddings and fresh fruit available for people to choose and we found that there were sufficient drinks available both on the table and around the home.

Everyone was asked what meat and vegetables they wanted on their plate and asked if they wanted gravy and if so, how much. All were asked if they had had enough or if they wanted more, as they finished their plate of food.

One person came to lunch a little later as most people were leaving and they were served with a roast meal. We noticed that they picked at their food, complaining that they kept telling staff that they didn't like a roast meal. They had bought into the dining room a tin of soup, which they asked to be warmed up and for staff to ensure that it was very hot. They complained to us that usually food was not hot enough.

Recommendation; That the provider has regards to recognised up to date guidelines and other relevant documentation related to dementia environments.

Requires improvement

Is the service caring?

Our findings

One person who lived in the home told us they had lived there for [number] of years, loved it and the food was excellent..

A staff member told us, "I want this home to be their family". Another said, "It's good here" and another said they would be happy for their relative to live at the service.

A social care professional had written in an e-mail that we saw in a care plan, "I feel that Waverley care home in particular, due to its cultural mix, is an excellent place".

A visitor to the service told us that as far they were aware they did not have any concerns about the care provided and they were always made welcome.

We saw that staff and the people who lived at Waverley care home appeared to get on well together. Staff were attentive, personable and involved people as much as they were able to be involved. We saw that mainly the staff gave information and explanations about any activities or interactions that the person was to undertake. However we also witnessed that staff knocked on people's doors but did not wait for a response before entering. We also saw one of the nursing staff administer eye drops to a person in the communal lounge and we did not hear any explanation given to the person about what was happening. This meant that this person's privacy and dignity had not been respected and information had not been given to them.

We found for one person that the weighing equipment for general use in the service was being stored in their bedroom. This was not appropriate as it was their personal space.

We saw in the dining room that one person was sat at a table with their back to the rest of the diners, during lunch. This person was looking at a wall. We noted that this was not conducive to any social interaction with the other diners. We discussed this with the staff on duty and this person was encouraged to change places so that they could interact with the other people eating their lunch. We saw this had a good effect but had not been identified by the staff members.

We saw that the minutes of a staff meeting held in February stated that end of life training was to be happening soon but we did not find any evidence that this taken place. However we found that end of life care was in place for a person using the service. Prior to moving in to the home an assessment of needs had been carried out and the care plan demonstrated that appropriate support was being provided by relevant members of the community nursing team. We noted in the plan that there was no record of spiritual needs for the individual. We spoke with a nurse who told us that it had been discussed with the individual who had not expressed any wishes for support but had not been recorded.

A staff member rang a taxi for a person who uses the service. As the taxi was going to be some time the staff member offered to walk with the person round the garden, when this was declined the staff member offered to sit with the person. She also asked if the person wanted the television on or off, or if they wanted the channel changing. This demonstrated that staff were supportive and offered choices to meet people's needs.

There were arrangements in place to support people using the service if English was not their first language.

There were few visitors seen on the day of the inspection as the majority of the people using the service were out for a large part of the day but people using the service and members of staff told us there were no restrictions in place.

Requires improvement

Is the service responsive?

Our findings

When we spoke to people who used the service one person told us 'I would speak to matron if there was anything wrong". A second person told us that they went out to different places that they chose to go to. A third person told us that they were in charge of offering people using the service a choice from the menu each day. It was their responsibility to take the menu to everyone using the service each day and ask what they would like to eat from the menu.

We asked staff how they knew how to care for people. One staff member told us, "I've caught onto caring for the residents. I know the daily routine. I read care plans. There is a sort of handover, we just tell each other if there's any problem. It's good here".

We asked to see the complaints file but were told that there wasn't one. We asked the manager if the service had ever had any complaints and were told no. We were also told that the service had been open for seven years and there had never been a complaint or a comment made. Because of the lack of information we were unable to determine if any concerns or complaints had been raised and how they had been dealt with.

We found that the care plans we looked at were comprehensive and included relevant information to support the individuals using the service. However we found that some of the language used in the care plans was very dated and not respectful of the person, such as comments, "She occasionally wet her pants", "Accepted her meals" and "No complaints". Each care plan had an identification sheet at the front of it with brief personal details about the person and a photograph of them.

The information contained in the care plans was person centred. However it was not clear whether the person or their relatives had been involved in the planning of their care throughout. There was a document in use called a New Admission Checklist. This was to record information such as: was the bedroom prepared; catering /dietary needs recorded; photograph in place and risk assessments and care plans in place. We found that a named nurse and carer system was in place in order that each person had two members of staff who were particularly responsible for their care and they were named in the care plans. Physical healthcare needs were recorded such as continence assessments and wound care plans and risk assessments for falls and skin integrity had been reviewed monthly. Referrals to relevant health care professionals had been made appropriately.

We saw that people had access to other services such as chiropody and opticians and their weights and blood pressures had been recorded regularly.

The records showed that the staff knew the individual needs of the people using the service. For example for one person it was recorded that they were more likely to stumble after smoking a cigarette.

Each person had a social activities log that recorded their preferences such as current affairs or listening to music. It also documented when they had been out of the service to a social activity.

When we arrived at the home there were activities taking place in the communal lounge. It was initially singing and then it developed into current affairs with one of the staff members reading out a newspaper and discussing the contents. We saw that there were plenty of activities occurring throughout each day, with a dedicated activities staff member. Another staff member spent two days a week assisting in the activities. People were taken out to lunch on the first day of our inspection and the following day we saw that there was bingo in the afternoon, which was well attended. We also saw armchair exercises being performed by many of the people in the home and that there was good discussion between people throughout. On the second day we saw that individual people were supported out to various locations in the community.

Representatives from the local churches visited regularly to conduct services in the home.

One of the people using the service did not speak English well but we saw that on a one-to-one basis, translators have been provided for this person and that their family visited often. This meant that this person's potential social isolation on a one-to-one basis was minimised.

Requires improvement

Is the service well-led?

Our findings

We asked staff if they thought that the service was well led and had mixed responses. One person told us they thought the deputy manager was doing well and had the support of other staff. Another told us “I can go to management about any problems". Another, however, said, "I am not happy here; you get no thanks for working extras. The way you get spoken to, some people speak to me like a child", and another told us "There is no manager here at the moment which is very unfortunate".

A person using the service told us of a concern that they had that had recently occurred. We found that this had not been documented. It appeared that the home was investigating the situation, even though the police and safeguarding had been informed. This was not the correct procedure and the CQC had not received a notification of this event as required by law.

We had received some information of concern about the way that staff and service users were being spoken to by a member of staff. We discussed this with the deputy manager and with other members of staff. We found that there were mixed views about this but we were concerned that the culture, leadership, openness and transparency of the management was compromised due to there being no registered manager for some time. In addition to those values, the work of registered manager was being undertaken by other staff. This would mean that staff were under more pressure and may be brusquer because of this.

There was no registered manager in place. The service had been without a registered manager for several months and had tried to recruit one. One applicant had been offered a position, references and other checks had been made, but this person had decided not to accept the position. At the time of writing the report we were told that the recruitment process was progressing.

Incident and accident audits had been regularly carried out up until March 2015 and showed how the incidents were analysed and learnt from. For example the staff changed how they helped a person who uses the service when they were standing. There have been no audits since then.

Relative Questionnaire audit carried out on 26 February 2015 was due to be reviewed and re audited in June 2015 but there was no evidence that this had been carried out.

We had a number of concerns about the lack of quality assurance processes in the home to monitor the service provision. There were no consistent processes in place to monitor health and safety, care plans, infection control, incidents and accidents, falls and safeguarding concerns.

We also noted that there was no monitoring of staff support and supervision by senior staff in the organisation.

The training records provided conflicting information to what the members of staff told us and therefore it was difficult to determine who had carried out what training.

Most of the policies that we looked at had been updated but would benefit from further review.

We had concerns about the overall knowledge of the management and overview of the service by senior staff employed by the provider. We discussed this during and following the inspection with senior members of staff in the organisation. They made a commitment to resolve the issues found.

These examples are breaches of Regulation 17 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not taken proper steps to ensure the proper and safe management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider had not taken proper steps to ensure that care and treatment of service users had been provided with the consent of the relevant person**