Platinum Care (Lincoln) Ltd

# Waterloo House

## Inspection report

Walesby Road
Market Rasen
Lincolnshire
LN8 3EX

Tel: 01673842343
Website: www.waterloohousecarehome.co.uk

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
Waterloo House is a residential care home providing personal and nursing care to up to 35 people. The service provides support to older people some of who are living with dementia. At the time of our inspection there were 27 people using the service.

People's experience of using this service and what we found
People were at risk of injury as their mobility needs were not safely assessed. Areas of the service needed repairs and could not be effectively cleaned; this increased the risk of injury and infection. Environmental risks were not mitigated, and people had access to areas where they could be harmed. Medicines were not securely stored. People were not always protected from the risk of abuse as the provider did not always inform the local authority and CQC of safeguarding concerns.

There were risks people's dietary needs may not be met increasing the risk of choking and complications associated with poor management of diabetes. The provider did not always make referrals to relevant professionals for people to have expert advice on managing their health-related conditions.

Quality assurance systems were not effective and needed improvement. There was a lack of management oversight in reviewing incidents and accidents. However, we found that the staff treated people with dignity and respect.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 6 December 2018).

Why we inspected
The inspection was prompted in part by notification of a specific incident. The information CQC received about the incident indicated concerns about the management of people's mobility needs . As a result, this inspection did not examine the circumstances of the incident.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the

overall rating.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Waterloo House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to people's safety, safeguarding, good governance, leadership and management of the service at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

| | |
|---|---|
| **Is the service safe?**<br>The service was not safe. | **Inadequate** |
| **Is the service effective?**<br>The Service was not effective. | **Inadequate** |
| **Is the service well-led?**<br>The service was not well led. | **Inadequate** |

# Waterloo House

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors 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.

Service and service type
Waterloo House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Waterloo House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
At the time of our inspection there was a registered manager in post, however they were not able to be present throughout the inspection activity. This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. Inspection activity started on 30 March 2022 and ended on 5 April 2022.

What we did before the inspection
We reviewed information we had received about this service since the last inspection. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with four people who used the service. We observed people and their interactions with staff and each other. We spoke with 11 relatives about their experience of the care provided.

We spoke with 11 staff members including a laundry assistant, kitchen staff, carers, a senior carer, the care manager, the operations manager, the quality assurance manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of care records. This included 12 peoples care records and multiple medication records. We looked at four staff files in relation to recruitment and training. We reviewed various records relating to the management of the service including health and safety checks and incidents and accidents.

Inadequate

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● People were at risk of injury as staff completing moving and handling assessments were not sufficiently trained or qualified to undertake these assessments. This resulted in unsafe practices that posed a risk to people. For example, during our second day of inspection, we found that a person was placed in a sling that was too big for them, following them falling from a hoist the day before. After our inspection, healthcare professionals recommended that people receive support in bed while they undertook assessments and the provider sourced mobility equipment in line with their recommendations.

● People were at risk of receiving food that was unsafe for them. Although support plans did contain information on meeting people's dietary needs, the kitchen staff were not provided with written information or care plans about people's dietary needs. Consequently, they had minimal knowledge about who had diabetes or needed modified food due to swallowing difficulties. This meant people were at increased risk of health complications and choking.

● People were at risk of harm from the environment. For example, we found plaster was coming off in a lounge following a leak and a broken plug socket with exposed wiring. We spoke with the provider, who took immediate action to fix the plug socket. The loft area was accessible to people and had evidence of a fly infestation, leaks, damaged areas and was full of equipment and stored items. Window restrictors fitted throughout the service had the keys hung up next to the windows meaning people could potentially open the windows. Some bathrooms were in a poor state of repair and posed a risk to people, we spoke with the provider about this and they consequently closed two bathrooms.

● The staff didn't actively think about environmental risks to people. We found wiring for call bells trailing and exposed in people's bedrooms during the first day of our inspection. This created a trip hazard for people, some of who were at high risk of falls. We made the provider aware of this and during our second day of inspection, the provider moved the wires to mitigate this risk. However, this continued to be an issue; professionals who visited the service to conduct assessments following our inspection documented trailing wires as a hazard. This means improvement in this area wasn't sustained.

Learning lessons when things go wrong

● The provider did not act on known risks following injuries to people. A record showed a person had cut their toes on broken tiling in a bathroom and the provider had not taken action to repair this area or restrict access to the area until its repair.

●The provider did not sufficiently review incidents. For example, records showed that one person was documented to have 15 falls from 29 January 2022 to 4 April 2022 and there was no documented evidence of actions taken to promote this person's safety. This also meant the provider did not analyse themes and trends from incidents to promote learning and improvement.

● The staff did not record enough information about incidents and accidents. This meant limited

information was available for the service to make informed decisions to reduce risks to people's care and safety.

Preventing and controlling infection

● Several bathrooms needed repair and refurbishment due to flooring coming away and damaged fixtures and fittings. This did not allow for effective cleaning and increased the risk of bacteria harbouring in those areas.

Systems and processes did not ensure people received safe care and treatment. The provider had failed to mitigate risks and ensure the safety of the premises. This placed people at risk of receiving unsafe care. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did not follow local and national guidance during a recent COVID 19 Outbreak. The outbreak affected all people using the service and significant amounts of staff. The provider had deployed staff who tested positive for COVID 19 as they could not make alternative staffing arrangements. However, the provider did complete a risk assessment for this decision.

●We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider's infection prevention and control policy was up to date.

● The provider facilitated visits for people in line with current guidance, people we spoke with also told us that their relatives were able to visit.

Systems and processes to safeguard people from the risk of abuse

● People were not safeguarded from the risk of abuse. There had been a failure to identify, refer and investigate incidents of a safeguarding nature. Furthermore, when we spoke with the quality manager regarding an incident, they told us, "We discussed if this was a safeguarding, but then I went on annual leave." This resulted in the incident not being reported or followed up.

The provider did not ensure that people were safeguarded from abuse and improper treatment. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had access to whistleblowing information. Staff told us the provider had whistleblowing information on display in the staff room and knew who to contact if they had concerns.

Staffing and recruitment

● Recruitment was managed inconsistently by the provider. For example, we found conflicting information held on staff files due to some staff being long-standing employees, including the right to work documentation and previous employment references. In addition, we found the provider did not have a process for following up on DBS (Disclosure and Barring Service) checks to ensure that staff were still suitable to work with people.

● The provider had started to work on plans to improve the quality of recruitment practices. Auditing from the quality assurance manager on staff records began in February 2022, resulting in a staff member being prevented from working due to insufficient recruitment checks. After our inspection, the provider told us they had reviewed processes and introduced a new recruitment checklist. We will review the impact of this and any improvements on our next inspection.

● We found enough staff on duty to meet people's needs during the inspection. The provider scheduled staff using an effective "rolling rota" system; this allowed staffing to be arranged in advance where shortfalls in staffing could be foreseen. A person we spoke with felt that there was enough staff on duty during day times.

Using medicines safely

● People's medicines were not stored safely by the provider. We found medicines stored in a cupboard locked only by a bolt which people could reach. This increased the risk of error or misuse. The provider told us that they would have a new lock fitted in response to this.

● Staff received training to give people medicines. For example, a staff member told us that they completed online training and regularly had their competency to support people with their medicines checked by the provider.

● People received their prescribed medicines safely. We observed a medicines round and found staff were competent in supporting people to take their medicines. Staff demonstrated an understanding of people's individual needs and preferences regarding how they liked to take their medicines. Records we reviewed in relation to medicines administration were correct and complete.

Inadequate

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff were not adequately trained in using mobility equipment and aids, resulting in people being injured by falling from hoists. Furthermore, the registered manager and care manager delivered staff training to move and position people without having the relevant skills and qualifications to provide this training. This put people at risk of unsafe practices. After our inspection, the provider told us they had organised moving and positioning training for staff from an external training provider.
- Mobility equipment used to train staff was not fit for purpose. During our inspection, we found slings that were no longer safe and should have been disposed of; when we asked the provider why they were present, they told us staff were placed in these slings as part of their training. This presented a risk of injury to staff.
- Records showed that not all staff received an induction when they started. This meant that staff may not have had the information they needed for their roles or confirmation staff understood standards expected of them.

The provider had failed to ensure that staff providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had opportunities to receive support from the provider. Records showed the provider held team meetings with the staff team, including separate domestic and kitchen staff meetings. In addition, staff told us they received supervisions and appraisals. This enabled staff to raise any concerns they had.
- Staff held daily handovers. Handovers discussed safety, people's needs, sharing ideas and planning day-to-day running of the service.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs

- Care plans and risk assessments were not always updated to reflect people's changing and emerging mobility needs. Records showed that people hoisted after a fall did not always have support plans or risk assessments before or after this intervention, increasing the risk of harm to people due to their moving and positioning needs not being planned or assessed.
- The provider did not always manage the environment according to people's needs. For example, signage indicating a bathroom on the first floor was being used as a storeroom for equipment and supplies.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other

agencies to provide consistent, effective, timely care

● People living with diabetes did not have robust support plans and risk management plans in place. In addition, the provider had not been aware before admission to the service two people had been diagnosed with diabetes; this only became known when the GP later informed the service. There was no information in care plans as to how staff should support people to manage their diabetes in the case of an emergency, which put people at risk of health-related complications. After our inspection, the provider reviewed and improved people's diabetes risk assessments in response to the concerns found.

● People did not always have referrals made to relevant professionals. For example, as mentioned in the safe section of this report, one person had experienced a significant number of falls, however, the provider had not made any referrals to the falls team. We also found that the provider had not made referrals to occupational therapists in response to people's changing mobility needs.

Supporting people to eat and drink enough to maintain a balanced diet

● The provider did not regularly update people's food preferences. Records had not been reviewed with people since 2019 and still contained information about people who were no longer supported by the service. A new kitchen staff member could not identify people as there were no pictorial identifiers on records and they told us, "I rely on the staff to tell me what people want."

● However, our observation of people's mealtime experiences was positive. We observed lunchtime at the service and found that people had appropriate support from staff to eat. The atmosphere was relaxed and unrushed. Where people required additional support to eat their food, the staff supported people in a dignified way. We spoke to a person who told us they enjoyed the food served at the service and were always offered two choices.

Ensuring consent to care and treatment in line with law and guidance

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 MCA 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The provider had made applications for legal authorisation where people needed to be deprived of their liberty. Records showed that the provider had followed up where authorisations had lapsed for the local authority to reassess authorisation.

● We observed staff seeking consent from people before completing care-related tasks such as giving people medicines and decisions relating to eating and drinking.

Inadequate

# Is the service well-led?

## Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements Continuous learning and improving care

- The provider's governance and quality assurance systems were not effective in monitoring and improving the quality of the service. Although the provider had a quality assurance manager supporting the service, their systems and processes had failed to identify and address all the areas of concern we found during our inspection. We discussed risks and concerns identified during the inspection with the provider; they told us, "We took our foot off the pedal."
- There was not effective management oversight of the service in the absence of the registered manager. The quality assurance manager told us they only had oversight of safeguarding concerns and did not oversee other areas of quality assurance.
- There was poor management oversight in the monitoring of incidents and accidents. We reviewed incidents and accidents recorded this year and found a lack of detail on what led to the event and what support people received during and after the event. In addition, managers were inconsistent around reviewing incidents and accidents that had taken place and taking action to reduce risks of future occurrences. This placed people at an increased risk of harm.
- Systems and processes to ensure the environment was safe for people were ineffective. As cited in the safe section of this report, people were at risk due to the provider's failure to ensure a safe environment. We could not be assured that the provider's systems would have independently identified the need to improve these areas to promote people's safety.
- Managers did not follow the provider's policies and procedures. For example, although the provider told us they had policies for people's mobility needs to be assessed by suitably trained and qualified professionals, managers did not follow this at the service, putting people at risk of harm and injury.
- Systems and processes to ensure people's dietary needs were met were ineffective. As cited in this report's safe and effective sections, the provider had not ensured people's dietary risks were appropriately mitigated and communicated with all staff, resulting in staff who directly prepared people's food not fully understanding people's nutritional needs.

Working in partnership with others

- The provider's processes did not effectively promote partnership working to help fully and safely meet people's needs. As cited in the effective part of the report, referrals were not made to external professionals when people's needs changed.

The provider failed to ensure adequate systems and processes were in place to assess, monitor and improve

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

We asked the provider to take immediate action to mitigate risks to people's safety in the areas identified above. After our last inspection visit, the provider informed us of action plans and changes they will make to improve the service and people's safety. The impact of these changes will be reviewed during our next inspection of the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Records showed the provider had not completed statutory notifications to CQC for notifiable events. We are looking into this further.
- Relatives felt they were informed when things went wrong. For example, one relative told us, "if there are any issues to worry about or even a slight slip, they keep us informed."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff treated people with dignity and respect. We observed staff interacting with people with good rapport. A person we spoke with told us that they feel people are "well looked after."
- Staff we observed understood how to engage with people based on their needs. We observed staff involving people in decisions by changing their approach to how people best understood information. For example, during a meal, we observed staff asking one person which of the two options they would like and staff bringing two plates of food to another person to choose which they would prefer based on physical objects of reference. We observed staff giving people medicines and saw that one person did not want to engage with staff and did not want their medicines at the time; staff took the time to speak with them to find out why this was and went back later once they had been given some reassurance.
- A relative told us in relation to how staff treated people, "They are so kind and they make sure [relative] is safe."
- Relatives were kept informed of people's progress. For example, a relative told us that the provider would send emails or call if there were any changes. Relatives also told us that the provider would communicate with them using newsletters and confirmed they had a chance to give feedback via questionnaires.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems and process for quality assurance, safety and effective management oversite were not effective |

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<br><br>Systems and processes did not ensure people received safe care and treatment |

**The enforcement action we took:**

We imposed urgent conditions on the providers registration with us. This included seeking written agreement from CQC for new admissions, completing and reviewing risk assessments, reviewing their systems and processes to investigate incidents and safeguarding concerns.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider did not ensure people where safeguarded from abuse and improper treatment. |

**The enforcement action we took:**

We imposed urgent conditions on the providers registration with us. This included seeking written agreement from CQC for new admissions, completing and reviewing risk assessments, reviewing their systems and processes to investigate incidents and safeguarding concerns.