Waypoints Care Group Limited

Waypoints Plymouth

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on 27 and 28 February 2017.

Prior to our inspection the Commission had received a concern that people were being unsafely supported with their mobility and that their bedroom furniture was not always repaired. There had also been reports from the provider and local authority of a high number of safeguarding incidents involving people walking into other people's bedrooms uninvited and of people causing harm to one another. The provider had also failed to notify us of significant events in line with their legal obligations.

Waypoints Plymouth is owned by Waypoints Care Group Limited. The provider also owns two other care homes in Dorset. The service provides care and accommodation for up to 64 people. On the day of the inspection 61 people lived in the home.

Waypoints Plymouth provides care for people with physical and mental health conditions which include people living with a diagnosis of dementia. The provider's philosophy of care was stated to be "Creating a sense of independence, normality and enjoyment" and "Supporting people with the least restrictions, ensuring their freedom, choice and control".

At the time of our inspection the service did not have a registered manager in post. The service was being managed by a Director of Waypoints Care Group Limited. A new manager had been appointed from 20 March 2017 and we were told would be registering with the Commission. 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.

At our last inspection on 08 August 2016 and 09 August 2016 we asked the provider to make improvements to ensure there were sufficient numbers of staff employed to meet people's individual needs; and to ensure people were protected from risks associated with their care. We also required the provider to improve practice in the service based on the findings of previous safeguarding investigations in order to keep people safe and free from avoidable harm and abuse. We requested the provider make sure people's care records were accurate and people's complaints were listened to. As well as ensuring there were effective governance systems in place to assess, monitor and improve the ongoing quality of the service.

In addition, we asked the provider to consider the ethos, management and culture of the service. This was because some relatives and staff had told us of inconsistent management approaches and poor communication. Following our inspection, the provider sent us an action plan telling us how they intended to meet the associated regulations. During this inspection we looked to see if improvements had been made. We found some action had been taken, but further improvements were required.

People were not protected avoidable harm that may affect their human rights, because people were able to

freely walk into other vulnerable people's bedrooms and cause harm. Although, this freedom of movement was the basis of the provider's dementia care ethos, consideration had not been given to how people were protected from experiencing psychological or physical harm. Previous safeguarding alerts and investigations carried out by the local authority had also shown similar themes; that the layout of the service did not always keep people safe and protected from harm.

People told us they felt safe living at the service. However one person told us they did not feel safe because, they were worried about other people entering their bedroom. They explained they had told staff, but nothing had changed. The preventative measures which were in place to alert staff when a person entered another person's bedroom uninvited, were not always effective and people did not always have a call bell in reach to be able to call staff for assistance when this happened.

People who lived at the service were not always supported to manage risks associated with their behaviour in order to protect themselves and others. People's behaviour was not always monitored to help understand the reasons for why they may behave in a certain way, in order to find possible solutions. People were not always cared for by staff who understood how to mitigate risks associated with a person's care, and risk assessments were not always in place to help provide guidance and direction to staff.

People lived in an environment which had been assessed to ensure it was safe; however people did not always live in an environment which was free from odour. Some people's bedrooms and shared areas smelled of urine.

People did not always receive their medicines when prescribed. People's medicines were administered by staff who had received training.

People told us there were enough staff to meet their needs and since our last inspection consideration had been given to increase the numbers of staff working within one area of the service. People were supported by staff who had received training in order to meet their individual needs, and nursing staff attended specialist clinical training. However, when training had been provided it had not always been put into practice.

People's consent to care had been sought and recorded in their care plans and staff were heard to verbally ask people for their consent prior to supporting them. Managers understood their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS).

People's confidential information was not always protected because their personal care records were not always locked away. People's privacy and dignity was not always respected. People's personal belongings were not always kept safe or respected by others living at the service.

People and their relatives generally told us staff were caring and we observed this during our inspection. However, some other people and relatives were not as complimentary. People and their relatives told us the food was nice.

People had care plans in place which provided guidance and direction to staff about how to meet their individual needs. However, care plans were not always effectively updated to ensure they were reflective of people's current care needs. People were supported to maintain their health and wellbeing by accessing external health and social care professionals.

People living with dementia were not always provided with personalised care. People's care plans were not

individualised to demonstrate how they were being supported with their dementia care needs. This was also reflected in some staff actions when they appeared to be more focused on completing tasks rather than meeting the social and emotional needs of people.

People could participate in social activities. There was a passionate and enthusiastic activities co-ordinator, who demonstrated through her actions the fundamental qualities of delivering good dementia care. However, some people spent their time walking around the building and staff did not always take the opportunity to make conversation or encourage different social stimulation.

People's complaints were spoken about positively by the management of the service, and were used to help improve the service. People were invited to come and talk about their concerns or worries. Managers said they were trying to change the culture by introducing an "open door" approach.

Since our last inspection, the leadership of the service had changed and although in its infancy, people, families and staff talked of improvements and a positive change to the atmosphere of the service. Families and staff were being asked for their views and opinions in order to improve the quality of the service.

The provider described the service as being in "transition". There was recognition and honesty throughout our inspection about the improvements which were required. The provider was open, transparent and had admitted when things had gone wrong. The provider worked in partnership with other external health and social care agencies. However, feedback from the local authority quality and improvement team (QAIT) was that the provider did not always lean from their mistakes.

The provider's governance systems had failed to ensure people were kept safe from abuse and avoidable harm. Audits were in place to help monitor the quality of the service; however these had not always been effective in identifying when improvements were needed. The provider's culture of a 'person centred approach' was not always observed to be imbedded into staffs practice.

The provider had organisational policies and procedures which set out what was expected of staff when supporting people. However, the provider had not ensured staff in day to day charge of the service had received an induction to the organisation which meant they were not aware of the provider's policies and procedures.

The provider had not always notified the Commission of significant events which had occurred in line with their legal obligations. However, the provider took action to rectify this and notifications were now being submitted as required.

Following our inspection, the Commission requested that the provider submit an action plan by 07 March 2017 to outline their intentions as to how they would immediately mitigate the identified risks to people. The provider also confirmed they would stop any new admissions to the service at this time. We also contacted the local authority safeguarding team who took prompt action to ensure people's health, safety and wellbeing.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from avoidable harm that may affect their human rights.

The provider did not learn from previous safeguarding investigations in order to keep people safe.

People were not always protected from risks associated with their care.

People's medicines were not always administered as prescribed.

People did not always live in an environment which was free from odour.

People told us there were enough staff to meet their needs.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported by staff who had received training in order to meet their individual needs; but when training had been provided it was not always put into practice.

People's nutritional needs were not always known to staff. People told us the meals were lovely.

People's consent to care was sought in line with guidance and legislation.

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

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not promoted.

People's confidential information was not always stored securely.
People on the whole were supported by staff who showed kindness and compassion, but some staff were focused on tasks rather than engaging with people.

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

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had care plans in place which provided guidance and direction to staff about how to meet their individual needs. However, care plans were not always effectively updated to ensure they were reflective of people's current care needs.

People living with dementia were not always provided with personalised care.

People could participate in social activities.

People's complaints were investigated and used to help improve the service.

Is the service well-led?

Inadequate

The service was not well-led.

The provider's ethos was not always imbedded into staff culture and practice.

The provider had not ensured staff in day to day charge of the service had received an induction to the organisation. This meant they were not aware of the provider's policies and procedures.

The provider had not ensured governance systems protected people and kept people safe from harm.

Systems and processes in place to help monitor the quality of care people received were not effective in identifying when improvements were needed.

The provider had failed to notify us of significant events in line with their legal obligations.

The provider and managers were open, transparent and

admitted when things had gone wrong. However, the provider had not always learned from previous incidents in order to improve the quality of the service.

Waypoints Plymouth

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We visited the care home unannounced on 27 and 28 February 2017. The inspection team consisted of one inspector, a specialist advisor of nursing care for older people and an expert by experience - this is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the provider had sent us since the last inspection. A notification is information about important events, which the service is required to send us by law. We also contacted Healthwatch Plymouth.

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

We also clinically pathway tracked four people. This is a process by which we follow a person's care experience through the service, to ensure their needs and preferences are being met in line with their care plan.

We spoke with six people who lived at the service, seven relatives, and fourteen members of staff. As well as the recently appointed head of care and two Directors of the Waypoints Care Group Limited. One of which was the provider's nominated individual (NI). A nominated individual is responsible for ensuring the services provided by the organisation are properly managed.

We looked at 13 records which related to people's individual care needs. We also looked at records that related to people's medicines, as well as documentation relating to the management of the service. These included auditing records, policies and procedures, accident and incident reports, training records, equipment and serving records, and kitchen menus.

After our inspection we contacted a nurse practitioner, a GP practice, a continence specialist nurse, a Parkinson's specialist nurse and the tissue viability nursing service. As well as a speech and language therapist (SLT), the local authority mental health team for older people, the clinical commissioning group (CCG) and the local authority quality and improvement team (QAIT) for their views about the service.

Inadequate

Is the service safe?

Our findings

At our last inspection on 08 and 09 August 2016 we asked the provider to make improvements to ensure there were sufficient numbers of staff employed to meet people's individual needs; and to ensure people were protected from risks associated with their care. We also required the provider to improve practice in the service based on the findings of previous safeguarding investigations in order to keep people safe and free from avoidable harm and abuse. During this inspection we looked to see if improvements had been made. We found some action had been taken, but further improvements were still required.

People were not protected from avoidable harm that may affect their human rights. The provider's philosophy of care was to create "A sense of independence, normality and enjoyment" and "Supporting people with the least restrictions, ensuring their freedom, choice and control". This meant people living at the service were able to freely walk in and out of shared areas, as well as into each other's bedrooms. Although, this freedom of movement was the basis of the provider's dementia care ethos, adequate consideration had not been given to how people were protected from experiencing psychological or physical harm.

For person who was unable to independently mobilise; we observed them sitting in their bedroom chair when a person who lived at the service entered their bedroom, uninvited and lay on their bed. Subsequently, the person fell asleep exposing some nudity. The person, who was unable to move of their own accord, was unable to call for assistance because they did not have a call bell in reach. The sensor mat which should have alerted staff to the person's presence was not working. Upon speaking with the person, they were visibly distressed by what had occurred and confirmed people came into his bedroom regularly.

Another person was observed to be asleep in their bedroom chair, whilst another person had made their way into their room and was asleep in their bed. We spoke with staff to confirm whose bedroom it was, and were told it was the lady who was sitting in the chair. Staff took action to wake up the person in the bed and guided them out of the bedroom.

The preventative measures which were in place to alert staff when a person entered a bedroom uninvited, were not always effective. For example, sensor mats were not always in place and switched on. We were told by managers that since our last inspection, the system for checking sensor mats had changed. These were no longer being checked twice daily, but instead being checked on a monthly basis which involved a manager standing on a sensor mat to observe staff response times.

Prior to our inspection, the Commission was notified of a safeguarding incident which had been investigated by the local authority and police. A person had entered another person's bedroom uninvited, and had disturbed them. As a result of this, preventative measures had been taken by the provider to help ensure this did not occur again to the person who had been affected. However, we were told that although the situation had improved, the person's relative had felt the provider had not acted quickly enough in order to protect their loved one". This contradicted the providers stated vision of "We ensure that all of our residents are cared for in a safe and compassionate way by having robust training and policies in place to prevent harm

or abuse occurring".

Although, preventative measures had been taken to protect this person, prompt action and consideration had not been given to others living at the service. "This was demonstrated by the high number of safeguarding notifications the Commission received at this time, detailing physical altercations occurring between people, some of which had been witnessed, and others which had not been. One relative told us the provider was too slow in rectifying problems being faced at the service and commented, "Doesn't my Mum have the right to feel safe in her own home". The provider told us that they wholeheartedly felt that the person's mother did have the right to feel safe in their own home".

We spoke with staff to obtain their views about the reasons for the high number of safeguarding alerts being raised. One member of staff told us, "X does not like noise, he punched out at a lady of 103. We try to redirect him from noise. I think some problems can be avoided if staff are more careful, but if they are in people's rooms giving care they cannot be monitoring what is going on".

Previous safeguarding alerts and investigations carried out by the local authority had also shown similar themes, in that the layout of the service did not always keep people safe and protected from avoidable harm. This demonstrated the provider had not reviewed their practices in line with previous safeguarding investigations and the recommendations made, in order to keep people safe. Families had also expressed at a meeting in December 2016 "That the traffic (people) entering bedrooms was too much and that the non-mobile residents are being put at risk".

At the time of our inspection the provider was already in the process of considering changes to the environment to help minimise risks to people, and these changes were due to take affect from May 2017. However, following our inspection the Commission asked the provider to submit an action plan to outline their intentions about how they would immediately mitigate the identified risks to people. We also contacted the local authority safeguarding team who took prompt action to ensure people's health, safety and wellbeing.

Staff received safeguarding training, but one member of staff was unsure of what action to take if they suspected someone was being abused, mistreated or neglected; despite having received training. However, the provider explained staff had access to the provider's safeguarding policy which gave clear information of what action to take should they need to contact external professionals.

People were not protected from abuse. Systems and processes did not operate effectively to prevent abuse of people. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always have call bells in reach to request urgent support when they needed it. For example, when we gave one person a call bell, they were surprised that it was there and told us they had not been given it before. They explained they usually shouted to obtain staff attention.

People who lived at the service were not always supported to manage risks associated with their behaviour in order to protect themselves and others. For example, we were told by a member of staff about one person who became physically aggressive if another person walked into their bedroom uninvited. We reviewed the person's care plan and associated risk assessments to establish how the person should be supported safely; and to determine what guidance was in place for staff to ensure risks were mitigated. However, the person's behavioural assessment chart had not been reviewed since 19 October 2016. This meant there was no clear plan in place for the staff about how to support both the person's psychological

wellbeing, and put into place preventative measures and manage potential risks to help keep them safe.

People's behaviour was not always monitored to help try and understand the reasons why they might behave in a certain way, in order to find possible solutions. For example, whilst one member of staff positively described how they had been monitoring one person's behaviour by completing behavioural presentation charts and sharing information at nursing handovers. Another member of staff described differently what action they took, by telling us "They get agitated, we wait until it gets too bad and then get a nurse to give medication".

People were not always cared for by staff who understood how to mitigate risks associated with a person's care, and risk assessments were not always in place to help provide guidance and direction to staff. For example, one member of staff was seen to assist one person with their lunch; their care plan stated that the person's meal should be 'fork mashable'. The member of staff who assisted the person with their lunch did so, while the person was in a lying down position. Therefore placing this person at risk of chocking. Also there were no risk assessments or associated care plans in place regarding this person's care.

An external professional told us they did not always feel incidents were analysed so lessons could be learned. For example, when a person had fallen.

Risks associated with people care were not always effectively managed to help ensure their ongoing health and wellbeing. Risk assessments did not always give guidance and direction to staff about how to help ensure people received safe care and treatment. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were unable to mobilise independently were supported by staff who had received training in moving and handling, which included how to use equipment safely. However, we were told by a relative that they had observed staff using an incorrect hoist sling when moving their loved one. The relative felt, that this had occurred because of ineffective communication amongst the staff team about changes to their loved one's care.

People did not always live in an environment which was free from odour. Some people's bedrooms and shared areas smelled of urine and cleaning schedules were not able to demonstrate when certain carpets had been cleaned. Whilst the provider had taken responsive action to replace the flooring in some bedrooms, managers were not aware of the other areas which had been identified during our inspection. An external professional also told us when they or their colleagues had been visiting people at the service that they also smelt urine, particularly in the reception area. Following our inspection we were informed by a continence specialist that they visited unannounced soon after our visit and found no odours. This demonstrated the provider had taken immediate action to rectify this issue immediately.

People did not always receive their medicines when prescribed. For example, one person had been prescribed a medicine to assist with pain relief. However records showed the person had been unable to have the medicine as it was out of stock. This demonstrated the systems in place for ordering medicines were not always effective in ensuring people received their medicines on time and kept people pain free.

The provider had a medicine audit which was used to identify where improvements were needed. However, the audit had not been effective in identifying when people's medicines were not in stock.

People's medicines were administered by staff who had received training. People's medicines administration records (MARs) were completed accurately to demonstrate when people received their

medicines. People received medicines reviews, and people's mental capacity in respect of taking medicines had been assessed when required.

People who were at risk of developing skin damage were supported effectively to ensure preventative measures were taken to minimise deterioration. Feedback from tissue viability specialists was complimentary. They told us staff listened, followed advice given and took a proactive approach to reduce a person's skin from deteriorating any further, whilst waiting for a visit from the tissue viability team.

People told us there were enough staff to meet their needs. Since our last inspection consideration had been given to increasing the numbers of staff working within one area of the service. One person commented, "They always have enough staff to look after me" and one relative expressed "There is too many staff at times, better to have that though than not enough". We were told by managers that there was a flexible approach to staffing, and should people's individual needs change from day to day, there was provision to increase staffing as necessary. The provider was in the process of adopting a new tool, to help assist in ensuring staffing levels were in line with people's own care plan.

People told us they felt safe living at the service, commenting "Everyone is so lovely, why wouldn't you feel safe". Relatives told us, "I know my wife feels safe, otherwise she would be anxious", "My dad feels safe because of his alarm mat" and "My relative feels safe because she has regular carers that she recognises and knows they are caring". One person told us they did not feel safe because, they were worried about other people entering their bedroom. They explained they had told staff, but nothing had changed.

People lived in an environment which had been assessed to ensure it was safe. Fire tests were carried out and equipment was serviced in line with manufactures requirements. People had personal emergency evacuation plans in place (PEEPs). These helped to give a summary of people's individual needs for the emergency services in an event such as a fire.

Requires Improvement

Is the service effective?

Our findings

People were supported by staff who had received training in order to meet their individual needs. The provider asked staff to undertake training in subjects such as, health and safety, privacy and dignity and infection control.

However, when training had been provided it was not always put into practice. For example, staff received dementia and person centred care training, with the provider stating 'Person Centred Care' is central to our philosophy and values". However, although some staff were observed through their interactions to demonstrate the principles of such training, other staff did not. For example, some staff were busy carrying out their duties, and did not always spend time socially with people. We saw that some people, for the majority of the day walked up and down corridors and in and out of people's bedrooms, sometimes without any acknowledgement from staff.

Nursing staff attended specialist clinical training, such as syringe driver, end of life care and catheter care. Nursing staff confirmed that if they required additional training to assist with their revalidation they would be supported with this. Revalidation is the process by which nurses have to demonstrate continued knowledge and competence in order to retain their formal nursing registration with the Nursing and Midwifery Council (NMC). An external professional told us, a lack of staffing competence sometimes meant that they were requested to visit people or provide advice unnecessarily. For example, one person who had nursing care needs had dry skin on their head, however staff were unsure about what action to take. In addition, they told us staff did not always use their 'common sense' before asking for external support.

There were not sufficient numbers of suitably qualified, competent, skilled and experienced staff employed in order to meet people's needs. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a training manager who was also responsible for mentoring and supporting staff, by carrying out one to one supervision and observation of practice. Staff were complimentary about the training they received and about the training manager. Comments included, "We have brilliant in house training" and "You can ask the training manager the same question 2,000 times and he will still go through it step by step".

Staff received an induction prior to commencing their role, to introduce them to the provider's ethos, policy and procedures and to provide them with mandatory training, such as safeguarding, fire, and dementia care. Staff told us support was "very good" and they received supervision of their practice. The training manager told us some staff had not been attending training, but since there had been a change of management, action was now being taken to address this formally.

One person told us, "I feel safe because they (the staff) are so good, clever and intelligent". Relatives told us, as far as they knew, staff had the correct training and skills to meet their relative's individual needs.

People who were at risk of not eating and drinking enough had been prescribed nutritional supplements and had records in place to record their daily consumption, this helped to identify if and when external healthcare referrals were necessary. However, people's needs were not always known to staff and records were not always being completed. For example, one person had been prescribed a nutritional supplement to be taken three times a day. However, the person's daily food and fluid charts had not been completed since 25 February 2017, when it had been recorded that one supplement had been given that day. We asked a member of staff to determine how many nutritional supplements should be offered, but they were unsure.

People's individual nutritional preferences and needs were communicated to the kitchen team to enable them to enjoy the meals they liked and ensure it was in line with their care plan.

People were supported to eat and drink. There was a flexible approach to meal times, which meant people could choose when and where they wanted to eat their meal. A member of staff told us, "We try to give the residents a varied choice of meals, but if there is nothing they fancy they can have what they want really". However, people living with dementia were not always asked what they would like to eat and drink. Also the menu which was handwritten and displayed on the wall may not have been in a suitable format for everyone to be able to read or understand.

People and their relatives told us the food was lovely. Comments included, "The food is thoroughly enjoyable", "Yummy scrummy is the food" and "My dad loves the food, he can't get enough of it".

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

People's consent to care had been sought and recorded in their care plans and staff were heard to verbally ask people for their consent prior to supporting them, for example before assisting them with their lunch or with their medicines.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Prior to our inspection we had been told people's bedroom furniture was not always repaired promptly. During our inspection, we did observe that some people's bedroom furniture required repair, for example handles had fallen off and drawers did not always close. However, action had already been taken to introduce a new recording system to try and improve communication between staff and the maintenance team, as to what and when things needed to be repaired.

Requires Improvement

Is the service caring?

Our findings

People's confidential information was not always protected because their personal care records were not always locked away. For example, offices through-out the service were not always locked when staff were not there, this meant people's care plans and records were readily accessible to those who were not authorised to view them.

People's records were not always stored securely. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider stated, "Privacy and dignity is very important in the way that we provide care to residents. We ensure that all our staff are appropriately trained and follow the ten principles of dignity in care as set out by the National Dignity Council". One of these ten principles included, "respect people's right to privacy". However, during our inspection we observed people's privacy and dignity was not always respected.

People were able to walk, uninvited, in and out of people's bedrooms, and on the whole this occurred without staff awareness. For example, we observed two people walk around one person's bedroom whilst they were asleep in their chair; another person entered a person's bedroom whilst they were being assisted with their lunch. One person told us, people often entered their bedroom, even in the early hours of the morning and stood at the end of their bed; they told us this made them feel anxious.

People's personal belongings were not always kept safe or respected by others living at the service. For example, one person entered a bedroom and started to pull the person's photographs and newspaper cuttings off the wall. Another person told us, papers, letters and money had gone missing from their bedroom.

People were not always able to identify their own bedrooms. For example, their name was not displayed on their door or a memory, such as a picture to prompt recognition of a person's personal space. One person had had to move bedrooms temporarily, however consideration had not been given to the importance of moving the person's belongings to their new room, to help them to identify with their new unfamiliar surroundings. A necessary action, when supporting people living with a diagnosis of dementia.

People when supported with meals were not always supported respectfully. For example, one pureed meal was observed to be mixed together into a soup consistency and then given. Prior to this, the person was not informed of what the meal was. There was also limited conversation between the member of staff and the person as they were assisting them.

The provider said within their vision statement that there was, "A 'person centred approach' of "Always saying hello whether it is the first time you have met a resident that day or the hundredth, because for them it might always seem like the first time" and "Laughing with staff and residents – good humour and fun are essential ingredients in a happy home". However, we did not always see this in practice, as some staff were more focused on tasks rather than engaging with people.

An external professional also told us during visits they had observed staff frequently congregate around the 'nursing stations' throughout the home, rather than engaging with people.

People were not always treated with dignity and respect. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, on the whole were supported by staff who showed kindness and compassion. Staff showed through their facial expressions and body language that they cared for people living at the service. For example, one person who had not managed to get to the toilet on time was observed to be supported in a very kind, skilled and compassionate way.

People and their relatives, overall told us staff were caring, comments included "They are brilliant, very caring", and "All the staff are lovely lovely people." A member of staff told us, "It doesn't feel like a job, it's just about caring for people in their home". External professionals told us that when they visited the service they observed kind and compassionate staff.

However, some people and relatives were not as complimentary, telling us "A couple of the staff are abrupt to me" and "Over the last twelve months the service and care have deteriorated enormously, I put this down to absence and lack of management in 2016". One person told us some staff called them "(…) Grumpy" which made them feel as though they complained frequently.

People were supported by staff who demonstrated kindness and patience when moving and handling equipment was being used. For example, time was taken to inform the person of what was happening and reassurance was provided to help try and alleviate a person's anxieties.

People and their families told us they were involved in decisions relating to their care. One relative told us, "I'm involved in making decisions about my wife and go through her care plan with her key worker", and "I'm kept well informed about my relatives care plan". A member of staff told us, "I always tell the relatives what's going on with their relative, change of mood, change of medicines, anything like that". However, people's care plans and records did not always demonstrate people's involvement in their care; but the provider had already recognised improvements were required, and an action plan was in place.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 08 and 09 August 2016 we asked the provider to make improvements to ensure people's care records were accurate and people's complaints were listened to. During this inspection we looked to see if improvements had been made. We found some action had been taken, but further improvements were still required.

People had care plans in place which provided guidance and direction to staff about how to meet their individual needs. However, care plans were not always effectively updated to ensure they were reflective of people's current care needs. For example, one person had received a visit from the mental health team on 16 December 2016. This visit had resulted in changes to the person's medicines and a medicines review had been booked for the following week. However, there was no further information about what the outcome of the review had been, and whether the changes made to the person's medicines had been successful; in order to ensure the person's needs were being met appropriately.

Another person's care records detailed they had experienced eleven falls since 29 January 2017. Hourly documentation had been put into place to document the person's levels of anxiety and agitation, however there was no evidence to show how the information had been used and no care plans were in place to support the person's psychological wellbeing.

People living with dementia were not always provided with personalised care. People's care plans were not individualised to demonstrate how they were being supported with their dementia care needs. This was also reflected in some staff actions when they appeared to be more focused on completing tasks rather than meeting the social and emotional needs of people.

An external professional told us, they felt people's basic care needs were met, but that people's care was not always individualised.

People did not always receive care and support which was designed to meet their individual needs and preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's continence needs had not always been assessed but action was being taken to rectify this. We spoke with the continence specialist who attended the service, who described the management of continence as having been disorganised. This was because there had been no key person in charge of the management of people's continence needs. However, she did explain that when she had recently visited the service, things were improving and assessments were now being carried out. She did however, feel continence care, "needed a clinical overview" and at the time of her visit it was being overseen by the training manager.

People were complimentary of the care they received and comments included, "I wouldn't like to live anywhere else", and "I hope they don't tell me I'm getting better, I don't want to go home". Relatives told us,

"I wouldn't want my wife to go anywhere else", "All our family are happy for our relative to live here" and "When our granddaughter visits her great grandmother she always asks why does 'Granny' live in a hotel?".

People and their families were encouraged to be part of their loved one's care plan and ongoing review of it to ensure it was relevant and met their needs. However, some families, whose loved one, had been at the service since 2014 had not been asked to participate in a care plan review. At the time of our inspection, the provider was taking action to rectify this.

People's changing care needs throughout the day were communicated at handovers, with one member of staff confirming this by telling us, "We have daily morning meetings with the heads of department to discuss any dietary needs or changes for the residents". A nurse practitioner attended the service every week to help respond quickly to people's healthcare needs and to ensure a consistent approach to people's ongoing care.

People could participate in social activities. There was a passionate and enthusiastic activities co-ordinator who, throughout our visit her actions and engagement with people demonstrated the fundamental qualities of delivering good dementia care. People told us, "I enjoy the sing a longs" and I "love playing table tennis, I was in a team at one time". Relatives were free to take their loved ones out at any time with one relative telling us, "I take my relative out for breakfast to the garden centre". On the days of our inspection, some people visited the coffee shop, listened to visiting musicians, took part in a film afternoon and participated in a game of table tennis. However, some people spent their time walking around the building and some staff did not always take the opportunity to make conservation or encourage different social stimulation. One member of staff told us, "The activities are not good enough. The more challenging residents are left out".

People's complaints were spoken about positively, and were used to help improve the service. People were invited to come and talk about their concerns or worries. Managers were trying to change the culture by introducing an "open door" approach. They wanted to encourage relatives and visitors to come and speak with them so as to try and prevent complaints from escalating unnecessarily. People's complaints were recorded, and the provider's policy helped to ensure complaints were thoroughly investigated and responded to in a timely manner.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 08 and 09 August 2016 we asked the provider to ensure there were effective governance systems in place to assess, monitor and improve the ongoing quality of the service. In addition, we also asked the provider to review the ethos, management and culture of the service. This was because some relatives and staff had told us of inconsistent management approaches and poor communication. The provider sent us an action plan telling us how they intended to meet the associated regulations. During this inspection we looked to see if improvements had been made. We found some action had been taken, but further improvements were required".

Waypoints Plymouth is owned by Waypoints Care Group Limited. The provider also owns two other care homes in Dorset.

Waypoints Plymouth provides care for people with physical and mental health conditions which includes people living with a diagnosis of dementia. The provider's philosophy of care is about "Creating a sense of independence, normality and enjoyment" and "Supporting people with the least restrictions, ensuring their freedom, choice and control. The provider also states within their vision statements that "Freedom of movement is of paramount importance at Waypoints Care…we actively encourage our residents to wander to each wing opposite their own with little or no restriction anywhere; including our reception areas and public lifts". However, whilst the provider's philosophy was the basis of the culture of the service, the provider's governance systems had failed to ensure people were kept safe from abuse and avoidable harm.

The provider's culture was stated to be a 'person centred approach' of "Always saying hello whether it is the first time you have met a resident that day or the hundredth, because for them it might always seem like the first time" and "Laughing with staff and residents – good humour and fun are essential ingredients in a happy home"; was not always observed to be imbedded into staffs practice.

Since our last inspection the leadership of the service had changed. The service was now being managed by a Director of Waypoints Care Group Limited. A new manager had been appointed from 20 March 2017 and we were told would be registering with the Commission.

A new head of care had been appointed in December 2016 and had responsibility for the clinical leadership of the service. During our inspection, the head of care was open and transparent about the challenges the service had faced and showed an honest and genuine approach about wanting to improve the service. Staff spoke highly of the new head of care describing her as "approachable" "supportive" and "brilliant". Minutes of a family forum meeting which took place in December 2016 detailed "Families would like to mention that the atmosphere in the home is a lot better on the whole". Staff had also been asked to complete anonymous questionnaires to share their views and opinions about the service.

The provider told us the service was currently in "transition". There was recognition and honesty throughout our inspection about the improvements which were required. External professionals told us, "It will be better when things settle down with the management" and also said that the clinical leadership of the service

needed improving.

Audits were in place to help monitor the quality of the service and to help identify if improvements were needed, some of which included, care plan, falls, medicines, infection control and environmental audits. However, these had not always been effective in identifying when improvements were needed in respect of medicine management, assessing risk, keeping records safe and secure, protecting people from harm, the accuracy of care records and the ethos and philosophy of person-centred dementia care.

System and processes in place did not always help to assess, monitor and mitigate risks relating the health, safety and welfare of people and improve the quality of the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had organisational policies and procedures which set out what was expected of staff when supporting people. However, the provider had not ensured staff in day to day charge of the service had received an induction to the organisation which meant they were not aware of the provider's policies and procedures.

The provider had not always notified the Commission of significant events which had occurred in line with their legal obligations. For example, regarding safeguarding concerns and serious injuries. However, the provider has taken action to rectify this and notifications were now being submitted as required.

The provider worked in partnership with other external health and social care agencies. However, feedback from the local authority quality and improvement team (QAIT) was that the provider did not always learn from their mistakes; and themes and patterns of poor practice and leadership which had been identified in 2013 still continued.

The provider was open, transparent and admitted when things had gone wrong. This demonstrated their understanding and recognition of the Duty of Candour. The Duty of Candour means that a service must act in an open and transparent way in relation to care and treatment provided when things go wrong. However, the provider had not always learnt from previous incidents in order to improve the quality of the service.

The provider encouraged open communication with people and their relatives. Family forum meetings took place on a monthly basis with one relative describing the meetings as "productive". A relative told us, despite recognising that improvements were required; "It is getting better" and positive recognition was given to the new management team for listening and taking action.

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 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care and support which was designed to meet their individual needs and preferences.

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with people care were not always effectively managed to help ensure their ongoing health and wellbeing. Risk assessments did not always give guidance and direction to staff about how to help ensure people received safe care and treatment.

The enforcement action we took:

We imposed a condition on the providers registration.

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 People were not protected from abuse. Systems and processes did not operate effectively to prevent abuse of people.

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People's records were not always stored securely. System and processes in place did not always help to assess, monitor and mitigate risks relating the health, safety and welfare of people and improve the quality of the service.

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced staff employed in order to meet people's needs.

The enforcement action we took:

We imposed a condition on the providers registration.