Waypoints Care Group Limited

Waypoints Plymouth

Inspection report

Ernesettle Lane
Plymouth
Devon
PL5 2EY

Tel: 01752360450

Date of inspection visit:
08 August 2016
09 August 2016

Date of publication:
18 October 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 8 and 9 August 2016.

At our last inspection on 30 June 2015 and 1 and 3 July 2015 we asked the provider to make improvements to how people's care was documented, ensure medicine records were completed accurately and that social activities were meaningful and planned in line with people's interests. During this inspection we looked to see if these improvements had been made and we found that action had been taken.

Waypoints Plymouth is owned by Waypoints Care Group Limited. The provider also owns another care home in Dorset. The service provides care and accommodation for up to 64 people. On the day of the inspection 58 people lived in the home.

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

The service had a registered manager in post. However, at the time of our inspection the registered manager was absent due to ill health. The service was being managed by the head of care, who was supported by the provider's operations director. 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 our inspection the Commission had received a number of whistleblowing concerns. These included, issues relating to staffing levels, people not always being kept safe from avoidable harm or abuse, the management of accidents and incidents, poor manual handling practices, the cleanliness of the environment and that staff did not always follow policy and procedures.

We were also told staff did not always treat people with dignity and respect, follow people's care plans and accurately record their care. Concerns had also been raised that nutrition was not effectively monitored, and people's continence and personal care needs were not being met. We were also told there was a lack of management and structure at the service, and complaints were not listened to or taken seriously.

People, relatives and staff told us there was not enough staff to meet their individual needs. Relatives also felt there was a lack of continuity of care for people, because staff worked across the service and not specifically in one area. Some external health professionals also shared this view. People were not always protected from avoidable harm and abuse because the provider did not always learn from previous safeguarding investigations. People were not always protected from risks associated with their care, for example risk assessments were not always followed.

People were protected by good infection control practices. Overall, the service was free from odour but in some areas there was a smell of urine. Relatives also commented about this, but explained they understood the challenges staff faced in meeting some people's needs. People's medicines were administered safely and the provider responded when errors in practice had been identified, for example by arranging additional training.

Overall, relatives told us they felt their loved one was safe living at the service. Staff knew what action to take if they suspected someone was being abused mistreated or neglected. Staff were recruited safely to work with vulnerable people.

People were cared for by staff who had received training and support. Some external health professionals expressed concern that staff were not always adequately trained to support people with dementia. People were encouraged and supported with their nutrition. A flexible approach to meal times meant people were able to choose and enjoy their meals when they wanted to. People had access to healthcare services to maintain their health and wellbeing. People's consent to care was sought in line with legislation and guidance to ensure their human rights were protected. People lived in an environment which was designed to support and empower them.

People were cared for by staff who were kind and compassionate. People and their families were supported to be involved in decisions relating to their loved ones care. People's privacy was not always respected because people had entered other people's bedrooms without their consent.

People had a pre-assessment prior to moving into the service, this helped to ensure staff could meet their needs. People's relatives, on the whole felt their loved one received good care, but some had concerns about the provider's ethos and whether it was always embedded into staff's practice. People had care plans in place to provide guidance and direction for staff about how to meet their needs. However, care plans were not always effectively updated to ensure they were reflective of how to meet people's individual needs. Some external health professionals told us, people's needs were not always met with continuity because of the use of agency staff at the service.

People's social activities were organised in line with their interests. Activity co-ordinators had a person-centred approach to meeting people's social needs, for example time was taken to get to know people. People's complaints were investigated and used to help improve the service. However, some relatives felt, some managers did not always effectively listen and take responsive action.

Overall, people, staff and relatives felt the service was well-led. Some however, felt there were management inconsistences. Some external health professionals expressed concern that staff were not always effectively supported.

People, relatives and staff were asked for their views about the running of the service. However, some people felt they were not always listened to. There were systems and processes in place to help monitor the quality of care people received. However, some audits had not always identified when prompt action was required.

The provider was keen to develop the service in line with current dementia research. The provider and managers were open and transparent and understood the requirements of the duty of candour. The Commission had also been informed of significant events in line with their legal obligations, for example safeguarding concerns.

We recommend the provider ensures that all staff receives training to effectively meet the needs of people with dementia, including challenging behaviour.

We found breaches of the regulations. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People, relatives and staff told us there were not enough staff to meet people's individual needs. Some relatives and health care professionals felt staffing was dis-organised which did not help to ensure a continuity of people's care.

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

People were not protected from avoidable harm and abuse, because the provider did not implement recommendations from safeguarding investigations and did not learn from mistakes.

Staff knew what action to take if they suspected someone was being abused, mistreated or neglected. Staff were recruited safely.

People were protected by good infection control practices to help prevent and control the spread of infection.

People's medicines were stored, managed and administered safely.

Is the service effective?

Good

The service was effective.

People were cared for by staff who received training and support to be able to meet their needs. Some external health care professionals told us staff would benefit from additional training.

People were supported and encouraged to eat and drink. A flexible approach to meal times meant people were able to choose and enjoy their meals when they wanted to.

People had access to healthcare services to maintain their health and wellbeing.

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

guidance to help ensure their human rights were protected.

People lived in an environment which had been designed to support and empower them.

Is the service caring?

Good

The service was caring.

People's privacy was not always respected because some people walked into other people's bedrooms with staff not being alerted.

People were cared for by staff who were kind and compassionate.

People and their families were supported to be involved in decisions relating to their loved ones care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

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

People's relatives, on the whole felt their loved one received good care but some expressed they did not feel the provider's ethos was embedded into staff practice.

People's complaints were investigated and used to help improve the service. Some relatives felt they were not always listened to.

People's social activities were organised in line with people's interests.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Some relatives and staff felt decisions made by managers were inconsistent, and did not help with effective communication and the running of the service.

People, relatives and staff were asked for their views about the running of the service. However, some people felt they were not always listened to.

There were systems and processes in place to help monitor the quality of care people received. However, some audits had not always identified when prompt action was required.

The provider developed the service in conjunction with current dementia research.

The provider and managers were open and transparent.

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 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.

We visited the care home unannounced on 8 and 9 August 2016. The inspection team consisted of one inspector and a specialist advisor of nursing care for older people.

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 spoke with six relatives, eight lifestyle assistants (care/senior care staff), three nurses, one activities co-ordinator, one domestic, the housekeeper, the catering manager and a chef. As well as, one receptionist, the training manager, the head of care and the operations director. The operations director was also the provider's nominated individual (NI). A nominated individual is responsible for ensuring the services provided by the organisation are properly managed.

We also spoke with a visiting pharmacist from the local Clinical Commissioning Croup (CCG) and an advanced nurse practitioner from a GP practice.

We looked at nine 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 three staff recruitment files, policies and procedures, accident and incident reports, training records, equipment and serving records, and kitchen records and menus.

After our inspection we contacted a GP practice, a continence specialist nurse, a Parkinson's specialist

nurse, a speech and language therapist (SLT) and the local authority complex care team for older people, for their views about the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 30 June 2015 and 1 and 3 July 2015 we asked the provider to make improvements to ensure medicine records were completed accurately. During this inspection we looked to see if these improvements had been made and we found that action had been taken.

The Waypoints philosophy was about "creating a sense of independence, normality and enjoyment". So with this in mind, people were supported with the least restrictions ensuring their freedom, choice and control. However, people's safety was not always maintained by effective decision making in respect of staffing. For example, on the day of our inspection a training course being held had resulted in staffing levels being reduced in one area of the service, meaning there had been two members of staff to support fifteen people. During this time, some people had been left unsupervised and were seen to walk into other people's bedrooms without staff being alerted, and one person fell. We reviewed the care plan for the person who had fallen and it stated the person was at "high risk of falls" and "staff need to be aware of where she is and ensure she is safe". We were told by management that staffing had been properly assessed to account for the reduction in staff.

We observed a further impact that reduced staffing levels had on people's care. For example, staff told us two people who enjoyed social activities and engagement with others could not attend the music afternoon because there was no available staff to be with them, to ensure they were safe. As a result of this, both people spent the afternoon in their bedrooms.

People's health and social care needs were met by lifestyle assistants (care/senior care staff), registered mental health nurses (RMNs) and registered general nurse (RGNs). This provided a mixture of skills, enabling people's physical and psychological needs to be met. However, relatives and staff told us they did not feel staffing was always adequate, giving us examples of people being unable to attend social activities, that they were not always able to find members of staff, and that the service sometimes appeared dis-organised.

Relatives also expressed they found the change of staff within each area difficult to understand, and felt the lack of staffing continuity did not benefit their loved one's confusion or achieve continuity of care. Managers explained staffing continuity was difficult to achieve because of people's varying needs, the staff rota and recruitment challenges. An external health professional also commented about staffing, and told us the use of agency staff to fill staffing vacancies, did not always effectively contribute to providing people with continuity of care.

Staffing at the service was not determined by the use of a dependency tool to help ensure staffing met people's individual needs, but by management listening to people's feedback and observing. We were told "The answer is not always to throw staff at it, we look at it holistically, the whole situation". Staff told us they did not feel enough consideration was given to skill mix, however following our inspection; further information was provided which showed the allocation of staff did take into account the importance of skill mix. The operations director also confirmed staffing at the service would be reviewed to ensure staff would not be taken off the floor for training, as had happened on the day of our inspection, ensuring that minimum

staffing levels were maintained at all times.

The arrangements for staffing did not always ensure people's needs were met. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People had risk assessments in place to provide guidance and direction to staff about how to keep people safe. When a risk had been identified, action had been taken to minimise the risk. For example, people who were at risk of climbing over bed rails had floor mattresses in place, which reduced the risk of the person becoming trapped. However, in respect of the person who fell, this demonstrated people's risk assessments were not always followed.

People were not always protected from avoidable harm and abuse that may breach their human rights because the provider did not always learn from previous safeguarding investigations. For example, as a result of a previous investigation, some people had been risk assessed for a sensor mat. Sensor mats alerted staff of people's whereabouts to ensure they were safe. However, people's sensor mats were not always switched on or in place. As a result of this, on occasions we saw people walk into other people's bedrooms and disturb them, and in some cases the person being disturbed was unable to express their dissatisfaction.

Monitoring checks were in place to ensure sensor mats were checked every hour to make sure they were switched on; however these checks had not always been carried out and documentation was not completed, a member of staff commented "It needs tightening up". Some relatives also expressed their concerns that the impact of not checking sensor mats, had on keeping their loved one safe. We spoke with managers about this who told us they would take action to speak with staff to ensure checks were being carried out.

The provider did not always take action to keep people safe and to mitigate risks associated with people care. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had risk assessments in place to monitor their nutrition when required, and when risks had been identified care plans were reviewed and action was taken, such as contacting a GP. People's skin integrity was also safely monitored to help ensure skin damage was prevented.

We observed how people spent their day to ensure they were kept safe. Where possible, staff encouraged people to have their walking aids with them. One person showed through their facial expression their confidence in being assisted to sit in a chair by a member of staff. The person responded positively to the staff member who showed kind reassurance by saying, "You are okay, I won't let you fall". Staff were observant when people became distressed with one another, and used appropriate distraction techniques to reduce people's frustrations.

People were protected by safe moving and handling practices, staff had received training and people had moving and handling risk assessments in place. We observed someone being supported to stand from the floor. This was carried out with correct moving and handling equipment and techniques, as well as with adequate numbers of staff; the person was re-assured by staff throughout to help alleviate any anxieties.

People who fell or had an accident, had this recorded so the information could be used to update people's care plans and associated risk assessments. People were supported and monitored following an accident

or incident, for example fifteen minutes checks were carried out and body maps were put into place to record bruising. People's falls were monitored for themes and to prompt necessary action. For example, records showed for one person who had been falling frequently, a request for a medicine review and a referral to their GP had been made.

People had personal emergency evacuation plans (PEEPs) in place; this meant emergency services would know how to correctly support people in an event, such as a fire.

People lived in an environment which was checked to ensure it was safe. For example, manual handling equipment was serviced and fire checks were carried out. However, we noted some of the provider's weekly fire tests had not taken place. We were told this was because there had been a change of staff. The operations director accepted this was not satisfactory and told us action would be taken to ensure this would not be repeated.

People lived in an environment which was cleaned each day to help reduce the spread of infection and minimise odours. During our inspection we found areas of the home odorous, and relatives also told us that at times, the environment did not always smell fresh. However, relatives explained they understood the difficulties and challenges staff faced. We spoke with managers about this who told us they had also noted an odour and had been liaising with different companies to obtain effective fragrances for the service. Staff, had received infection control training and were seen to wear personal protective equipment (PPE), such as gloves and aprons when carrying out tasks such as personal care or the serving of meals. The kitchen environment had been awarded five stars from the Environmental Health Officer (EHO), the maximum award achievable.

People were protected by staff who had been recruited safely. For example, Disclosure and Barring Service (DBS) checks were carried out to ensure people employed were safe to work with vulnerable people. Gaps in employment history were scrutinised and references were obtained from an employee's previous employer.

Staff had an understanding of safeguarding procedures and knew what to do if they had concerns someone was being abused, mistreated or neglected. Records showed appropriate action had been taken to contact relevant agencies when concerns had been raised.

People's medicine were managed, stored and administered safely. Medicine audits to help monitor the safe administration of people's medicines were carried out on a monthly basis. In response to the outcome of an audit, additional medicine training had been requested from the pharmacist for staff to improve their practices. The labels of some topical medicines (creams) were illegible which did not ensure they were being administered as prescribed, so the service had been working with the pharmacy to find alternative ways of improving this.

Medicines which required refrigeration were stored correctly and fridge temperatures were recorded. The operations director explained the administering of people's medicines was being reviewed, as at present a medicine trolley was not used but it was felt, this may make medicine practices more efficient in the future.

Good

Is the service effective?

Our findings

People received care from staff who received training and support to ensure they were effective in their role. Staff attended training in supporting people living with dementia and staff, through their interactions, showed an understanding of dementia care. People responded positively with conversation, a smile or laughter when supported or assisted by staff. Relatives told us they felt staff had the skills to look after their loved one with one relative telling us, "The care is first class and the staff are well qualified and well trained". However, some external professionals told us they did not feel all staff had adequate training to meet the needs of people, for example coping with challenging behaviour.

A new in house training manager had been recruited to make sure the training was of a high quality and interwoven with the provider's ethos and philosophy of care. The training manager spoke passionately about making sure staff received the training they needed to be able to meet each person's individual needs, telling us, "Our residents change constantly, so we have to adapt". The training manager explained the importance of supporting staff commenting, "If people want to work here, our residents get better care, and that's our ultimate goal".

When concerns had been raised about staffing competence the provider had been pro-active in identifying how improvements to their training could be made. For example, a manual handling competence assessment had been introduced following concerns about poor moving handling techniques. This helped to monitor and support staff to ensure they were working to the expected standards. A 'compassion observation assessment' had also been introduced to review staffs' practice in different areas of care provision such as in respect of personal care, supporting people with eating and drinking or with social activities. The 'supportive' assessment enabled staff to obtain feedback about their working practices. It also meant the provider was able to assess that the philosophy of "person centred care based around an individual" was being embedded into practice.

Staff told us there were training opportunities available and they received one to one supervision of their practice. Some staff however told us, the frequency of supervision varied. Managers explained this was because there had been a change in the line management of some staff, but this would hopefully now improve. Clinical training and supervision was provided for nursing staff to help ensure their professional competence was maintained, ensuring continued registration with the Nursing and Midwifery Council (NMC). The NMC is the regulator for nursing and midwifery professionals in the UK.

Staff received an induction when they started work, to introduce them to the philosophy of care of the service, help familiarise themselves with policies and procedures and with day to day routines. The provider also ensured staff received important training such as fire and safeguarding. The care certificate was in place for people who did not have any experience of the care sector. The care certificate is a national induction training programme, to ensure staff work to the desired standards expected within the health and social care sector.

People were observed to enjoy their lunch, with a flexible approach which met their needs. For example,

some people started to eat their chosen meal but then decided they did not like it, so were offered other alternatives.

People were supported by staff at lunch time as needed. Staff were respectful and considerate of people's needs. Staff were knowledgeable about what people liked to eat and drink, and were observant when people were not eating their meals. Time was taken to understand why this was. For example, staff recognised the reason for one person not eating their meal, was because they did not want to sit next to someone. The person was encouraged to change seats and as a result ate their lunch. A member of staff ate their lunch with one person as it was recognised they ate more when they could copy the knife and fork action of another person.

Relatives told us they felt meal times were sometimes disorganised and people were not always effectively monitored or supervised. The managers told us they were working with families to help them to understand the reasons why lunch times may present in this way and relatives were being reassured their loved one had enough to eat and drink at meal times.

The catering staff were empathetic to people's needs, and had a good understanding of dementia care and how this impacted on people telling us, "We are always learning, we adapt to people and their needs". The menu included people's likes and dislikes developed from the use of observation and feedback from people, relatives and staff.

The catering staff were looking at ways to improve their menu and crockery to better meet the needs of people with dementia, for example displaying the menu in a pictorial format and by using colour contrast for plates.

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, when a person resisted support this was respected.

We checked whether the service was working within the principles of the Mental Capacity Act 2005(MCA) and whether any conditions on authorisations to deprive a person of their liberty were being me.

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).

Manager's understood their responsibility in relation to the MCA and associated Deprivation of Liberty Safeguards (DoLS). People's care plans recorded their mental capacity when required, and DoLS applications to the supervisory body had been made when necessary. Some staff had received training in respect of the MCA legislative framework and had a good understanding, whereas some staff's understanding was limited. The training manager told us they would take action to help ensure all staff improved their knowledge.

People had their health needs met. People's changing care needs were referred to relevant health services. People's care records demonstrated a variety of health care professionals were contacted as necessary. For example, community nurses, opticians, chiropodists, and speech

and language therapists (SLT). An advanced nurse practitioner visited weekly to help with people's continuity of care.

Some families felt the service did not always chase up healthcare results, such as blood and urine results. We fed this back to the operations director who told us he would speak with clinical staff.

The environment had been designed to help ensure people living with dementia were supported and empowered. For example, lighting in bathrooms came on automatically and pictorial signage helped people familiarise themselves with areas of the service.

We recommend the provider ensures that all staff receives training to effectively meet the needs of people with dementia, including challenging behaviour.

Good

Is the service caring?

Our findings

People's dignity was promoted by staff who understood how important this is, for example people were supported discreetly when they required assistance in shared areas, with their continence needs. People's privacy was not always guaranteed by some people living at the service, because some people walked into their bedrooms with staff not always being alerted. The managers told us they would review how this was managed within the service.

People were observed to respond positively to staff, this was shown by people's facial expressions or by them entering into conversations. It was clear from people's smiles and laughter that they enjoyed staffs' humour. People approached staff without hesitation, held their hands or sat next to them. One person was observed to sit beside and listen to a member of staff playing the piano; the person relaxed and drifted off to sleep.

Relatives also confirmed staff were kind commenting, "They are very good with her" and, "A very caring nature, the management has a good eye for selecting the right people in tune with dementia care". People's relatives had also written thank you cards to express their appreciation of the kindness shown by staff, stating, "Thank you all for everything you did…and kindness shown to us on our visits to him" and, "Everyone who looked after Dad, we cannot thank you enough, you all deserve a medal for all what you do, and have done". External professionals were also complimentary of staff, with one describing staff as "Very, very patient".

We observed very caring staff who treated people with compassion and adjusted their approach to each person. Staff spoke fondly about the people they cared for, telling us, "I love it, I'm addicted to the place" and, "It's all about our residents…we will bend over backwards for them". An external health professional described the service as "friendly with a nice team".

People's families were welcomed and invited to be part of their loved ones care. For example, one relative explained how they had shared with staff, the way in which they had supported their loved one prior to them moving into the service. So as a result of this, staff knew the best approaches to take.

People's relatives were invited to social events and were able to arrange family gatherings, where the catering staff had provided buffets. Family forum meetings were held which gave an opportunity to discuss their views with managers. People's birthdays were celebrated. Each person had their own birthday cake, and the chef made a larger one for others to enjoy too.

Staff showed kindness and inclusiveness towards people when they walked into staff meetings or training sessions, for example people were welcomed and always invited to stay. People were free to attend interviews of new staff and staff spoke respectfully of people's valuable contribution.

People were shown respect and dignity at the end of their life and families were supported. A relative had taken the time to write in appreciation of the care their loved one had received stating, "We very much

appreciate the support …for the sensitive way in which they (the staff) handled a difficult and sad situation". Staff received training to ensure they provided a high standard of care and compassion at this time. The provider was working in collaboration with a local hospice to provide nursing staff with specialist training to promote the best end of life care.

Requires Improvement

Is the service responsive?

Our findings

People had care plans in place to provide guidance and direction for staff about how to meet their needs. When people's needs changed, care plans were not always updated which meant people's records were not always reflective of their current needs. For example, staff described how one person was supported with their continence; however when we read the person's care plan the guidance for staff was different. We also observed the person was not supported in line with their care plan or as described by staff. As staff worked in different areas of the service, it was essential for care plans to be up to date to ensure the continuity of people's care. Some relatives also expressed their concerns, and told us they did not always feel staff had the most up to date information, for example about how to effectively support their loved one at lunchtime and with promoting them to go to the toilet.

Some external health care professionals told us they did not feel people's needs were managed with continuity. They told us they were contacted at times by staff to ask questions about people's care which was already known by the service, such as how to manage specific behavioural challenges. They felt the frequent use of agency staff was the main reason for this. However, the operations director told us they did always try to ensure they requested the same agency staff, which helped ensure a better understanding about people's on going health and social care needs.

People's relatives were on the whole, pleased with the care their loved one received with one relative commenting, "I can't fault it, it is superb… would recommend the home". However, some families felt the provider's ethos of "person-centred care based around an individual care plan" was not always being delivered. For example, ensuring people had their hearing aids in and their glasses on, did not always seem like a priority for staff. The provider told us that they faced challenges, as some people did not always like to wear certain items. They explained they always had to weigh up the balance of the level of distress that maybe caused by supporting someone. They also told us that some people took their hearing aids out and glasses off; and whilst these were checked regularly throughout the day, there could be no guarantee that the person would be wearing them when their relative visited. The provider told us they recognised they needed to be open with families with regard to their expectations and that all relatives were invited to attend dementia training, which focused on emotional memory and the consent and best interests of the their loved one.

People, prior to moving into the service had a pre-assessment to help ensure the service and staff could meet their needs. This was also an opportunity for the provider's philosophy of care "creating a sense of independence, normality and enjoyment" to be shared with families. A 'getting to know me' document was completed to help staff understand what a person had achieved in their life, prior to being diagnosed with a dementia. This helped staff meet the person's needs in an individualised way, to have meaningful conversations, and to help ensure social activities were tailored to people's preferences.

An external health professional told us staff asked for advice and implemented recommendations. They shared an example of how staff had been very patient and had persevered with different continence aids for one person, helping to promote the person's dignity and improve their quality of life.

People were able to participate in group or one to one social activities. Social activities were organised in line with people's interests, and relatives were being asked for their input at family forum meetings. One relative told us their loved one enjoyed music and explained the opportunities which were available. We observed their loved one participating in a one to one singing session; the person was seen to enjoy the music and the uninterrupted time with the activities co-ordinator. Another person had been emotionally withdrawn, so time had been taken to have a discussion with the person's family. During the discussion they found out the person used to enjoy table tennis, so the activity had been introduced. During our inspection we observed the person participating and enjoying a game with staff.

People and their relatives were encouraged to raise concerns, and one way in which people could do this was at the family forum meetings. According to meeting minutes of the family forum meeting in July 2016, family members who had attended, felt staffing levels were improving and concerns were dealt with. However, some relatives felt they were not always being listened to. For example, some had shared views about staffing, but did not feel any action had been taken.

People's complaints were investigated and when someone had complained, the registered manager had apologised. Complaints were used as an opportunity to reflect and improve the service. For example, complaints linked to staff practice had prompted additional training and one to one supervisions, and complaints about the laundry, had resulted in a new lost property room being created.

The provider was in the process of creating a new tool which would help to enable people living at the service to better express their views and feelings. This would help the provider to be assured people were happy with the care they were receiving.

Requires Improvement

Is the service well-led?

Our findings

Waypoints Plymouth is owned by Waypoints Care Group Limited. The provider also owned another care home in Dorset. The Waypoints philosophy was about "creating a sense of independence, normality and enjoyment". With this in mind, people were supported with the least restrictions ensuring their freedom, choice and control.

The provider's ethos was introduced to new staff, at their induction and underpinned by training and supervision thereafter. Through discussions and observations, we could see the ethos was incorporated into staffs' practice. Relatives however, felt the provider's ethos and philosophy of care did not always ensure their loved ones needs were met, because of a lack of staffing continuity which meant staff did not always know the up to date needs of their family member. The provider told us they had invited all relatives to attend training sessions on dementia care so that they could better understand the ethos of care. They also explained the registered manager operated an open door policy for any relative who want to talk and that there was a formal complaints procedure which was referenced in the relatives' handbook.

The provider had quality monitoring systems to help identify quickly when improvements were required. For example, audits in respect of medicines, care planning, infection control, and complaints were in place. However, some of the audits had not been robust enough in identifying when action was required. For example, the care planning audit had not identified that records were not always accurate and reflective of people's care, and people's sensor mats were not always being switched on and checked in line with the provider's procedures.

The provider had not always learned from previous safeguarding investigations. For example, monitoring checks which had been put into place to ensure sensor mats were switched on, had not always been carried out and documentation was not being completed.

People, relatives and staff were asked for their views about the running of the service, by the completion of questionnaires or by attending meetings. Some felt their views were listened to and respected, whereas others told us some managers were not as receptive.

Regulation 17 (1) (2) (1) (2) (a) (b) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not always listen and act on feedback from others in order to improve the service for people. The provider's systems and processes, to help ensure the ongoing monitoring and quality of the service were not always effective.

People's families had also been asked to monitor the ongoing quality of the service. For example, one relative told us they performed audits in respect of the environment. They told us recommendations which they had made, had been listened to and implemented.

There was a management structure in place at the service, which included the operations director, who was also the provider's nominated individual (NI), a registered manager and a head of care. Overall, staff felt the

service was well-led and they were encouraged and motivated by managers. However, some staff felt there was favouritism amongst certain managers towards some staff, resulting in an inconsistent approach to the management of the service and poor communication. We spoke with the operations manager about this, who explained a recent staff survey which had been carried out in July 2016 to gauge staff morale, had been on the whole, positive and that there had been no mention of favouritism or inconsistent approaches.

Some external health professionals told us they felt the service was well-led, but others expressed concern that staff were not always effectively supported and adequately trained.

In the absence of the registered manager, the head of care was in day to day charge of the service. People approached the head of care, spoke and engaged comfortably with her. In the registered manager's absence, the head of care was knowledgeable about people and the day to day running of the service. Her passion for the provider's ethos was apparent throughout our discussions. The head of care felt supported by the registered manager and explained they had one to one meetings and supervision. In the registered manager's absence, the head of care was being supported by the operations director, who they told us visited frequently. There was a management on-call rota in place to help ensure people and staff received management support at all times, which included weekends.

Daily meetings were held with all heads of department to help with effective communication across the service. Those who attended told us the meetings were useful and gave an opportunity for essential information to be shared such as, changes to people's diets and new admissions to the service. Senior management meetings also took place to provide support to each other and discuss the day to day running of the service. The provider had created a development plan; the plan was used to help managers reflect positively on the past and present, as well as considering future plans and strategies for the service.

The service was underpinned by a number of policies and procedures, made available to staff and these were reviewed in line with changing regulations. Staff told us there was a whistleblowing policy in place and explained they would feel confident about raising any concerns with managers. The operations director's number was also freely available for all staff to access, should they wish to speak with someone other than the registered manager or head of care. The provider also had a mobile phone policy to help ensure people's confidentiality and privacy was not compromised. Staff confirmed they understood the policy by commenting, "We are only allowed them in the staffroom, not on the floor".

The outcome and ratings given by the Commission of the provider's last inspection had been displayed in line with regulations, and we had been informed of significant events in line with their legal obligations, for example safeguarding concerns.

The managers and provider were open and honest, they responded professionally and promptly to the Commission and external agencies when required. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

The provider was keen to develop the service in line with research, for example the service was currently working in conjunction with Plymouth University in respect of how people with dementia can positively communicate through art and non-verbal expression.

Managers explained they were keen to work and support families, and told us a dementia awareness workshop was being delivered to families and friends, to help them to better understand their loved one's diagnosis.

Following our inspection, we received an action plan which detailed what the provider was going to do in response to our inspection feedback. This demonstrated a professional and pro-active approach to the running of the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment of service users was not always provided in a safe way. The provider had not assessed the risks to the health and safety of service users and had not taken reasonable steps to mitigate risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (1) (2) (a) (b) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems and processes were not always effective to assess, monitor and improve the quality and safety of the services provided. The provider did not act on feedback from health and social care professionals in order to improve the service for people. The provider did not always listen and act on feedback from others in order to improve the service for people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) of the Health and Social Care

Treatment of disease, disorder or injury

Act 2008 (Regulated Activities) Regulations 2014.

The arrangements for staffing did not always ensure people's needs were met.