Waters Park House Limited

Waters Park House

Inspection report

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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

The inspection took place on the 2 and 3 February 2017 and was unannounced. We last inspected the service on the 13 February 2015 and found all requirements were met. The service was rated as 'Good' in all areas.

Waters Park House (known locally as 'Waters Park') is registered to provide care with nursing for up to 23 people. They support people who have experienced a brain injury or a diagnosis which impacts on the brain such as Huntington's or a stroke. People may have mental health, physical disabilities or a sensory impairment as a result of the impact of their condition.

There was a registered manager appointed to oversee the service. 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. They were supported by a care manager, nurse lead and multi-disciplinary team. Carers, speech therapists, a physiotherapist, occupational therapists, nurses and a psychologist were all employed in assessing and meeting people's complex needs. These make up the MDT (multi-disciplinary team).

Prior to the inspection we received a number of concerns through whistle-blowers. This raised concerns about some staff having the language skills to meet people's needs. Also, concerns were raised in relation to staffing and whether people were having their one to one care as required. We also received concerns from families about whether their loved ones were receiving appropriate care and how the service responded to concerns when they were raised. We raised these issues with the registered manager and care manager and reviewed them as part of this inspection. We found some problems in respect of people's records and leadership, but did not find evidence to support all the matters that were raised with us.

We found improvements were needed to the way the provider monitored the quality and delivery of their services. This included how they sought feedback from people about their care and the services they received.

The registered manager was not telling us of events in the service they are required to tell us about by law. We were not being told about serious injuries, safeguarding incidents and all decisions on deprivation of liberty applications.

The service had a personalised approach to managing the risks people faced. There was a strong emphasis on people being able to understand the risks associated with their condition, behaviour or/and lifestyle in respect of their rehabilitation. However, improvements were needed to records of risk assessments.

People's medicines were administered safely. Staff managed medicines in a way that kept people safe. Medicines were stored securely. We saw nurses and senior carers gave medicines to people in a caring and

encouraging manner. Some medicines were prescribed to be taken when required (PRN). The written guidance for PRN was not as robust as it could be, but we observed that staff knew people well and therefore, were able to make decisions with them about whether a medicine was needed or not. The nurse manager told us that she was developing personalised written guidance for staff about when to give 'when required' medicines. An audit was in place to check on the safety of medicine administration. Any issues identified were followed up.

People were supported by a sufficient number of competent staff to meet their needs and keep them safe. Staff told us they felt there were enough staff on duty to enable them to meet people's needs. Staffing levels ensured people had their allocated one to one care staff with them as reflected in their care records Staff were recruited safely. People were assessed on admission to ensure staff could meet their complex needs. Staff had the necessary training to meet people's needs and were checked to be competent before working with people.

People admitted to the service had their capacity assessed. The service was working within the principles of the Mental Capacity Act 2005 (MCA) and ensuring any conditions on authorisations to deprive a person of their liberty were being met. The service was not recording MCA assessments on admission; staff have looked at this since the inspection to improve practice. Staff were observed seeking consent from people in their day to day interactions. People were given time to respond.

People had their nutritional and hydration needs met in a personalised way. Staff looked for creative ways to ensure people had enough to eat and drink. People's likes and dislikes were known and special dietary needs catered for. Food was prepared so it was available at certain times. In addition, people were encouraged to eat and drink where and when they would like. People contributed ideas to the menu. Concerns were monitored and followed up by the in house speech and language team (SALT) and external dieticians. People who required staff support to eat and drink were treated sensitively.

We observed the staff supported people throughout our time at the service with kindness, respect and in the person's own time. Staff worked quickly and as a team to diffuse any tensions. People were encouraged and given all the support necessary to be in control of their care and treatment.

People's needs were responded to in an individualised manner. People had their healthcare needs met. As part of the MDT, people's health and rehabilitation needs were under constant review and were part of a holistic assessment process. People were supported to access health services in the community; only having visits arranged to the service when there was no other option. People said they could see their GP and other healthcare staff as required. Staff were proactive and reflective in meeting people's needs; staff were patient and t constantly aimed for people to reach their potential following their injury or developing a condition that affected the brain. People were provided opportunities to remain active and stimulated.

Staff felt valued and listened to when they suggested changes in how the service was run. They felt the registered manager, care manager and nurse manager were approachable. The care manager, nurse manager and registered manager supported a culture that was open, inclusive and which learned from incidents and events.

We found breaches of the regulations. You can find what we have told the provider to do at the back of the full report on our website.

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's risks were managed in a personalised way but the records of risk did not provide assurances that they were managed safely.

People's medicines were administered safely.

People were protected by sufficient numbers of staff who were trained well.

People's finances were kept safe.

Is the service effective?

Good

The service remained effective.

People were assessed in line with the Mental Capacity Act 2005. The service was working to improve the assessment of people's capacity on admission.

People were looked after by staff who were trained to meet their needs.

People's nutritional and hydration needs were met.

People had their health needs met.

The service was adapted to meet people's needs. People had the equipment available to meet their rehabilitation and changing needs.

Is the service caring?

Good

The service remained caring.

People were cared for by staff who treated them with kindness and respect.

People spoke highly of staff. Staff spoke about the people they were caring for with fondness.

People were in control of their care. Staff were passionate about ensuring this and listened to people.

People said staff protected their dignity.

People were encouraged to make decisions about their future treatment choices.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were met in a personalised way. The records did not always reflect the person's current needs and were not always being updated.

People were provided opportunities to remain active and stimulated.

People had the opportunity to raise concerns and complaints and these were investigated.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had not been sending all notifications as required. This meant CQC was not being told about events in the service as we should have been.

People's care and services was not monitored effectively and their views on the service were not always sought.

People were provided with care from staff who felt supported and valued.

Waters Park House

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.

The inspection took place on the 2 and 3 February 2017 and was unannounced.

The inspection was completed by one adult social care inspector, a pharmacist inspector, a specialist nurse in conditions that affect the brain and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the information we held about the home. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

During the inspection the ex-by-ex spoke with as many people as we could. Some people could not talk to us; we observed how they and staff interacted in the lounge and dining room.

We reviewed the care records of six people in detail. We reviewed records in respect of the administration of medicines; we observed medicine administration for six people, examined nine medicines administration records (MARs) and two care plans to check people's medicines.

We reviewed four personnel files and the training for all staff. We spoke with nine staff. We reviewed how the registered manager was ensuring the quality of the service. This included audits and maintenance records.

Family did not visit when we were inspecting, we advised family could speak to us after the inspection if they wanted to by the use of posters and staff telling them. No feedback was received for us to include in the report.

Requires Improvement

Is the service safe?

Our findings

Improvements were needed to ensure staff had a way of knowing people's risk and be able to prioritise them appropriately through reading people's records. For example, the service did not identify which risks needed assessing, despite them telling us most people could be at risk of falling, developing pressure sores, choking (due changes to their swallowing/eating) and behaviour or mood changes. Where risk assessments were in place these did not always reflect the current level of risk. This meant staff did not have information, within records, to help them understand which risks to prioritise. Other risks associated with people's medicines, smoking and diabetes had not been assessed.

Although the original risk was included in the initial assessment in people's files people'srecords often jumped to assessment and treatment. They did not always record the original risk in a risk assessment. There was therefore no review of this risk and showing it was or had been mitigated. Reviews of people's risks remained in the records of the multi-disciplinary meetings and were not then transferred to people's individual records. Where written risk assessments were in place the individual risks were often not updated. Where people had experienced a fall for example, there was no evidence this had been formally risk assessed in at least one case, or the original risk assessment updated for another person. Changes made to people's records were then not signed or dated. This meant records of risks were not accurate or complete and staff would not be able to refer back to the assessments for guidance.

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

We spoke with the care manager, nurse manager and registered manager about the risk assessment process at the service. We highlighted that the records did not reflect the practice of the MDT and which staff verbalised to us and we observed. Different staff within the MDT approached the inspection team on the second day of the inspection to discuss how they wanted to see the risk assessment process improve; the MDT meeting on the following week would start to address this process.

Despite the above records issues, the service had a personalised approach to managing the risks people faced while living at the service. There was a strong emphasis on people being able to understand the risks their condition, behaviour and /or lifestyle posed in respect of their rehabilitation. People's risks were identified and reviewed through weekly multidisciplinary team (MDT) meetings and support and treatment was then put in place to minimise risks for people.

Most people had risk assessments in place that reflected their behaviours and clear plans were in place to manage these. This included staff being trained in restraint if needed. Staff were always visible and worked as a team; staff acted quickly to distract people from conflict and intervened promptly when people's moods changed. The service had a no restraint policy but the action of staff reduced the likelihood that this would be required. Staff we spoke with had a clear understanding of each individual person's risks and how these impacted upon them and others. Staff described risk management plans changed for people over time as rehabilitation plans were put into place and reviewed.

People's medicines were administered and managed safely by staff. Medicines were stored securely in the treatment room and in people's own rooms. Medicines were within the manufacturer's expiry date and kept within the required temperature range meaning they were safe to use. Medicines, including those for minor ailments, were available to people when they needed them and unwanted medicines were disposed of safely.

We saw nurses and senior carers gave medicines to people in a caring and encouraging manner. Some medicines were prescribed to be taken when required. Whilst there was little written guidance for staff to follow, we observed that staff knew people well and were therefore able to make decisions with them about whether a medicine was needed or not. The nurse manager told us that they were developing personalised written guidance for staff about when to give 'when required' medicines. This would then be built into people's individual records.

Staff completed medicine administration records (MARs) to show what medicines people had received after administration. We saw two MARs had gaps where staff had not signed when a medicine had been given. The registered nurse told us that this had been identified as an issue through auditing. Additional staff training had been put in place to reduce the likelihood of this reoccurring. When staff made handwritten entries or amendments to MARs, they were nearly always signed by a second member of trained staff to show they had checked for accuracy.

One person was having their medicines given covertly (disguised in food or drink). Whilst the medicines were given safely, in the person's best interest and at the recommendation of a consultant; there were no records in the service of a mental capacity assessment, best interest decision or review. The registered nurse followed this up straight away and addressed this to ensure people on covert medicines were then assessed in line with the Mental Capacity Act.

Medicines were administered by registered nurses or trained care staff. Staff had their competency to administer medicines checked regularly and further training had been arranged where required. Medicines errors and incidents were recorded, reviewed and learned from. The registered nurse undertook regular medicines audits to identify areas of improvement, a recent audit had identified further information was necessary for 'when required' medicines.

People felt safe living at Waters Park. People were observed to be comfortable with staff. One person said, "Yes, I feel safe living here." And another, "Yes, I definitely feel safe here; they are very security conscious."

People were looked after by staff who understood how to identify abuse and what action to take if they had any concerns. Staff said they would listen to people or notice if people's physical presentation or emotions changed which might indicate something was wrong. Staff would pass on concerns to the care manager. All staff felt action would be taken in respect of their concerns. Staff said they would take their concerns to external agencies, such as CQC, if they felt concerns were not being addressed.

People were supported by sufficient numbers of competent staff to meet their needs and keep them safe. Staff told us they felt there were enough staff on duty to enable them to meet people's needs. Staffing levels ensured people had their allocated one to one care staff with them as reflected in their care records. Staffing for other people was flexible so their needs could be responded to immediately when they required additional support. Many staff had worked at the service for some time which ensured people received consistent care from staff they knew well. We discussed with the registered manager and care manager how they knew they had enough staff as they did not use any defined system such as measuring dependency, call bells response times and the number of falls or accidents people had. They advised they would look at

this as it would help to evidence this for the staff who had raised staffing concerns in the past.

People were supported by staff who were recruited safely. Robust recruitment practices were in place and records showed checks were undertaken to help ensure the right staff were employed to keep people safe. Staff confirmed these checks had been applied for and obtained prior to commencing their employment with the service.

People's finances were kept safe. People had appointees to manage their money where needed. Money was held securely and staff kept a clear audit trail of incoming and outgoing expenditure.

Good

Is the service effective?

Our findings

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 met.

The 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 were not having their capacity to consent to live at the service assessed. Every person who resided at the service would require an MCA assessment due them having a brain injury or related condition affecting the function of the brain. Therefore, in order to assess whether the person was able to consent to reside at and be cared for by the service, this would require an assessment of their capacity. People who lacked the ability to consent were not then being assessed as to whether they required a Deprivation of Liberty Safeguard (DoLS) application made on their behalf prior to or on admission. It was not therefore evidenced the decision for people to reside at the service was in their best interests.

We spoke with the care manager and registered manager about the assessment of people's capacity in line with the MCA. Different members of the MDT approached the inspection team to discuss how they would improve the admission process to ensure people's MCA status was known. Staff told us they did consider people's capacity at this time, but agreed the recording was not clear; they were focused on what their role would be post admission. The MDT advised their next joint meeting would address this.

Once admitted, capacity assessments were in place for specific issues, so staff could understand where they were acting in someone's best interests and where the person was able to make decisions for themself. Staff adhered to the principles of the MCA and maintained an oversight of the person's MCA as part of their rehabilitation. They assumed the person had or would regain the right to consent to their care and treatment. As people rehabilitated, people were more and more involved in consenting to their care and treatment. Every practical step was taken to ensure this with the staff being very focused in achieving the best for each person; going to any level to facilitate the person's ability to control their life at Waters Park. This including utilising local advocacy services and electronic communication. Staff spent time with people to understand how that person communicated what they wanted and how they wanted their care to be. Interpreters were employed for people whose English was not their first language to ensure staff could understand people as fully as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). Applications had been requested for some people and others were being reviewed as to whether they required a DoLS. Some of these were awaiting review by the local authority designated officer. Where DoLS had been authorised, staff made every effort to ensure the least restrictive practice was then in place. For example, one person had an authorised DoLS in place, but it was

felt that their overall support plan would benefit from them accessing the community as long as this was supported by two staff at all times as they had no understanding of their own risk status. Also, staff aimed to reduce the need for people to have the need for a DoLS as their condition improved.

Staff were observed seeking consent from people in their day to day interactions with people. People were given time to respond.

People were looked after by staff trained to meet their individual needs. The provider had a number of mandatory training courses in place which staff were expected to complete. This included first aid; fire safety; manual handling; safeguarding vulnerable adults; infection control and food safety. Staff also underwent a detailed induction and other training as identified. The service had not introduced the Care Certificate. The Care Certificate has been introduced nationally to train all staff new to care to an agreed level. All staff employed are expected to have the minimum qualification Health and Social Care at level 2. If this isn't in place when employment commences, staff are signed up within a month to commence their level 2.

People living at the service had complex needs that required specialist care. Staff were trained to meet these needs. For example, one person on a ventilator and with a tracheostomy required specialist equipment and full multi-disciplinary care. Before they were admitted staff were trained in how to manage the care at the NHS unit they were being transferred from. Staff were not allowed to carry out specific interventions unless they had been assessed and signed off as competent. In this person's comprehensive records there was evidence of regular advice and liaison from the NHS specialist respiratory care service to ensure staff continued to have the skills needed to meet this person's needs.

Staff were supported to maintain their individual professional registrations and attended higher levels of training in social care. Staff received regular supervisions and checks of their competency. External supervisors were employed for staff who required clinical supervision relevant to their field.

Staff told us there was a strong ethos of training and professional development of staff and utilising up to date practice. Staff could attend relevant training nationally and would then share the learning within the staff team; looking for the most appropriate application of this training in the service. One staff member said, "We are always learning; we learn together" and another, "We can ask for any training and support in any area. [The care manager] reminds us we can talk at any time." The psychologist for the service was available to support and help staff to understand people and their needs; staff were encouraged to reflect on their practice to continue to build on their knowledge and skills and remain, as one staff member said, "Fresh".

People had their nutritional and hydration needs met in a personalised way. Staff looked for creative ways to ensure people had enough to eat and drink. People's likes and dislikes were known and special dietary needs catered for. Food was prepared so it was available at certain times. However, people were encouraged to eat and drink where and when they would like. People contributed ideas to the menu. People were positive about the food quality, portions size and confirmed they could ask for something else if they did not like what was on offer.

People who required staff support were assisted in a calm and attentive way. SALT assessments were in place for people with swallowing difficulties. Nutrition and fluid charts were in place where required ensuring intake of food and fluids was monitored. Staff designated to assist a person to get up in the morning were also responsible to attending to their dietary needs, which gave a sense of continuity. Concerns could be quickly picked up and passed to the MDT. Those who needed specialist nutritional

support, such as through a Percutaneous Endoscopic Gastrostomy (PEG) or Radiologically Inserted Gastrostomy (RIG) were attended to by appropriately trained staff.

The kitchen staff had worked at the service for a number of years and ensured they got to know people living at the service. They knew people's individual characters and how their moods affected their willingness to eat sometimes. They knew how to react to people and what to provide for people at this time. The positive way they worked added greatly to how people felt about the service. These important details about people were not always documented. We discussed this with the staff concerned as their knowledge was invaluable and enhanced people's care.

People had their healthcare needs met. As part of the MDT, people's health needs were under constant review and reviewed as part of a holistic assessment process. People were supported to access health services in the community; only having visits arranged to the home when there was no other option. People said they could see their GP and other healthcare staff as required. People added that this was always achieved without any delay. Records detailed people saw their GP, specialist nurses, opticians and dentists as necessary. People also had regular medicine and health assessments with their GP or practice nurse. Any advice from health professionals was documented and linked to their care plan to ensure continuity of care and treatment.

Specialist equipment tailored to the needs of the individual was in place. The MDT worked closely together to ensure people had the equipment necessary for their rehabilitation; this was amended in line with people's changing needs. There were also mini-kitchens in some rooms, so families could be involved fully in the person's life. This also assisted in promoting independence and assessment of people's self-caring capabilities.

Good

Is the service caring?

Our findings

The atmosphere in the service was calm and people were observed to be happy in the company of staff. People were encouraged to mix with each other. Some people's social presentation was not always positive and could have had an adverse effect on other's experience at the service. Staff were always present and worked as a team to prevent this escalating. Staff used appropriate humour as a tool to communicate and diffused situations quickly. We observed staff supported people throughout our time at the service with kindness, respect and in the person's own time.

People told us, "It's alright, the staff are always helpful", "The (care staff) do their best to help me out", "The girls are lovely and friendly; some staff have been here for years", "I feel pretty positive; there are a lovely lot of carers coming in to care for me" and, "I think I am well cared for".

All the staff talked about the people they looked after with passion and a caring attitude or with fondness. Staff described a strong ethos of care led by the MDT.

One staff member said, "I enjoy working here; there is so much variety. Each person's needs are unique and I get to spend the time with them they each need." Another staff member said, "We put each person first; we are very person-centred. Everyone is an individual. Even if their diagnosis is the same as another person, their journey is different and they are treated accordingly." A third member of staff said, "I enjoy it here; I would recommend the home to a family member."

People were in full control of their care in line with their capacity and current ability. Staff believed every person would improve and rehabilitate. Once a person moved into the service, every effort was made to ensure the person participated in their care. Staff believed people would eventually take back full control of their care. Staff described an ethos of "never giving up" on people. As people's recovery slowed down, work would continue to support people to have a full say about their care. Staff often talked to us about how they went "back to the drawing board" and looking for every opportunity to help a person improve.

Advocates, specialist health staff, interpreters and communication equipment were utilised to support people to have full control of their care. Staff that spoke one person's language were employed to support their communication; staff were reliant on this person's eye movement and facial responses and by using staff who spoke their language and an interpreter, they were as close as they could be to ensure the person's view was heard.

People told us staff protected their dignity at all times. We observed offers of care in public areas were offered unobtrusively. All interactions from all grades of staff we discreetly observed, were respectful. Personal care was delivered in a thoughtful way; people unable to respond verbally were given explanations of the care being given. Staff were trained through an ongoing programme to ensure high standards were maintained.

People were encouraged and supported to make decisions about any future treatment; the service's

psychologist worked closely with people, family, relevant health and social care professionals to support people to make informed decisions about their future. Support through equipment, advocacy services and interpreters were used as required. People's end of life decisions were discussed and recorded as needed. Families were supported to understand the changes in their loved ones since they acquired their brain injury or needed to move into Waters Park. The psychologist, for example, would meet with family members to support them in their journey of loss and understanding how people's needs and reactions had changed.

Requires Improvement

Is the service responsive?

Our findings

People had full care plans established that detailed their needs at that time and staff role in their rehabilitation. When we spoke to staff about people's current needs, staff remained clear what their role was in meeting people's needs. This was via the use of reviews in the MDT, staff handovers and dedicated time to learn about people's individual conditions such as Huntington's. The care records did not always reflect the person's current care status. Some sections of people's care plans were undated; others had been written some time ago. Care plan sections were not always reviewed and where reviews had been added these were not always signed and dated. It meant the process of auditing the records was difficult. For example, one person's records stated they moved to the service in June 2014. They had parts of their care plans dated November 2014, September 2015 and May 2016. Some areas of the care plan had no date recorded. Where reviews had taken place, no date or signature was then recorded. For example, in the "dietary needs" section it stated the person had seen a dietician but there was no date in the care plan when the section was completed or when they had the dietician appointment. This record had also not been reviewed to check that staff were following the plan or whether it had been updated in line with the person's progress.

When we spoke to members of the MDT, we were advised there was no system as to when the written care plan was updated. Staff told us people new to the service had their assessments and treatment programme up dated often, those with longer term needs at greater intervals. People's care records did not demonstrate this way of working was being applied with any kind of pattern to everyone. Also, many records contained a lot of spelling mistakes within them which would have been evident to the reviewer.

When we spoke with the care manager and nurse manager, about the standard of care records we established care plans were not being audited. Had the care plans been audited, they would have seen that the records were not always reflecting people's current situation or being kept to a high standard for each person.

This is a breach of Regulation17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were looked after by a team of carers, physiotherapist, OTs, a SALT, psychologist and nurses. However, nursing assessments did not stand out or were not evident in people's records as the rest of the assessment and treatment plans completed by the other members of the MDT. The nurse manager had recognised this and showed us the new format for nursing care plans. These would then be kept with people's medicines care plans and MARs. The new records would include people's health goals, a review and emergency plans for each person as identified. There would also be a baseline risk assessment for each health condition.

People were cared for by staff committed to them reaching their potential in life having experienced an event which meant their brain had been impacted. All staff were knowledgeable about individual people's needs. We heard staff working well together, across disciplines, whilst planning care. Individual staff

demonstrated a commitment and passion in the service they were delivering. When we enquired about certain people, staff were able to speak about their histories and on-going needs, without referring to notes. People's records matched what staff told us.

People's needs were carefully assessed prior to them coming into the service. Needs were assessed by a team from the MDT. Generally, an OT, physiotherapist, SALT, nurse and a team leader completed detailed initial assessments. The person was then reviewed at the MDT meetings to discuss whether the service was the most appropriate one for them and could meet their needs. Consideration was always given to those already at the service. A comprehensive package of care was then proposed; ensuring all equipment was in place and staff had the required training before the person moved in. An initial care and treatment care plan was developed with all staff briefed about the person's needs. The person, family and existing care team were involved in developing the initial plan.

When the person moved into the service an intensive time started for the staff team and person. The initial care plan was reviewed at each weekly MDT or as needed in the days in between. People had a treatment programme in place involving the physiotherapist and other in house staff such as the OT, SALT, and psychologist. We observed staff responded as needs arose with people having extra time with staff as they needed or wanted. For one person, flexibility suited their condition as behaving in an erratic way was a side effect of their brain injury and meant their rehabilitation needs were met in a personalised way. One person new to the service told us, "I have not been here very long but I have made progress since I came here."

People's care needs were planned in a personalised way incorporating their culture and their identity such as their faith. Every effort was made to respect people's individual status. For two people whose first language was not English, interpreters were used to facilitate discussions and planning with staff. Electronic communication devices were also used to help people 'talk' to staff.

People, who had been in the service for some time and had plateaued in their rehabilitation, were supported to continue to push for the best outcome by setting new goals. The care manager told us, "We never say never to people". One member of staff said, "We have an MDT review if someone is not improving as we thought; we reflect with each other and feedback to all staff in the handover each day and change our responses as needed." Another member of staff said, "We have a strong MDT where we discuss and set SMART [specific, measurable, agreed upon, realistic and time-based] goals. We have a holistic approach and are 'doing in action'. Different parts of the MDT complete joint sessions with people if that is needed."

People were provided with the opportunity to go out into the community. One person said they were "bored" and another said they wanted more opportunities to go out but was observed going out to the park both days we were there. Staff time was given for people to utilise the park opposite and the terraces around the outside of the building. Staff were observed carrying out one to one sessions with people and a group activity. Interest in the group activity was short lived which staff described as normal. One staff member said, "We have men and women's groups, outings and therapy as a group. We engage and involve everyone as we can." Another staff member described how activities had both a social and therapeutic angle. "We have timetabled activities which are linked with people's cognitive development, shopping and finances. People can go shopping, to the theatre, hydrotherapy or cook a meal with staff" adding, how they can use these opportunities to see how people have progressed in their rehabilitation. We also saw one person go out for a meal with staff on the second day. This was treated as special with a choice given to where they wanted to go. Everyone dressed smartly. When they returned, a big fuss was made of them; staff keen to hear how their outing had been.

People's concerns and complaints were taken seriously. People told us they would speak to staff if they had

a concern. Staff told us they would respond if a person's mood changed and try and establish if something was wrong. People with electronic communication would be encouraged to use this in their own time. Any formal complaints were then investigated and we could see this was thorough. We asked how people who complained received feedback and found this did not include written feedback in one case. The care manager rectified this straight away and sent a letter to a family member who had complained. This detailed the details of the enquiry and apologised that the family had felt the need to complain. One person said, "I have lived here a while; I can't think of any improvements."

Requires Improvement

Is the service well-led?

Our findings

Waters Park was owned and run by Waters Park Ltd. They own and run two services in Plymouth. There was a registered manager who was also the director of the company and nominated individual (NI). Both the registered manager and NI are responsible for supervising the management of the service. The care manager managed the day to day running of the service supported by the nurse manager and MDT.

The service had not been sending us all notifications as required by law. CQC had not received notifications in respect of safeguarding and serious injury. Our records showed we had not been sent any of these notifications in the past two years. Concerns had been raised by a family, for example, that raised concerns about possible neglect. At least one incident of serious injury was made known to us and the care manager was going to review the records. We had also not being notified of all decisions about applications to deprive people of their liberty (DoLS). Our records showed two people had decisions about their liberty logged with us. However, DoLS applications had been applied for and we had not always been notified about the outcome. This was whether the application had been approved or denied.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

Since the inspection we received the notifications as identified. The registered manager has also told us about new events as required.

The provider was not ensuring there were clear systems in place to measure the quality of the service. Some systems were also not effective in identifying the issues we found during the inspection. The MDT was overseeing people's care, but there was no formal review of the systems to ensure good governance. A number of audits were not being completed. There were no audits for infection control, call bells, whole home falls, accidents and incidents and care plans. This meant there was no evidence of learning from events to support improvement. For example, if care plans had been audited fully, it would have identified the issues around risk assessments, Mental Capacity on admission and the need to update people's care records.

People told us there was no way to formally feedback about the quality of the service. One person spoke to us about how it would be good to have more opportunities to feed back about the service as a whole; they told us there were no residents' meetings or comment cards. Another person wanted to have more control over the locking of their room. We passed these comments onto the care manager who agreed to speak to those involved and look for ways to formalise feedback.

This is a breach of Regulation17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our records did not demonstrate an up to date statement of purpose had been submitted to us with a clear indication of the age group of people they would provide care for. We spoke with the registered manager about the age groups and statement of purpose and they stated they would ensure this was addressed. We

will check this in place during our next inspection.

The service's culture emphasised the importance of people being central in the management of their care and treatment. The care manager, nurse manager and registered manager supported a culture that was open, inclusive and which learned from incidents and events. Staff and people worked collaboratively together.

There were regular staff meetings to keep all staff informed and the opportunity to contribute ideas on how the service was being run. Staff told us they felt supported by being part of the MDT and by the care manager, nurse manager and registered manager. Staff told us that personal and professional concerns were listened to by all three of the managers. Staff felt they were given enough time to reflect on ways to review how they could improve the service. All staff felt they could blow the whistle on any practice issues and be heard.

One member of staff told us how there was a progressive process to the service's development, "Waters Park is a unique service; we utilise different approaches, are responsive and enquiring. We are constantly updating, revising" while delivering complex care packages. Other staff said, "I feel valued; able to contribute to change. We have healthy discussions as a therapy team"; "The service is run well; [the registered manager] has made themselves available to be there if [the care manager] can't be" and, "[The registered manager, care manager and nurse manager] are all approachable and feel safe talking to them if I have concerns. I feel I can voice concerns within the team and get my point across; we have regular 'team meets' every day. There is then a commitment to following things through."

We discussed the duty of candour with the registered manager to ensure this was in place when dealing with people's complaints and concerns. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment and apologise when something goes wrong.

The registered manager had systems in place to ensure the building and equipment were safely maintained. The utilities were checked regularly to ensure they were safe.

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 18 Registration Regulations 2009 Notifications of other incidents Regulation 18(1)(2)(a)(e)(4A)(a) The registered persons had not notified the Commission as required in respect of serious injury, abuse and deprivation of liberty safeguard applications.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1)(2)(a)(b)(c) Systems and process had not been established and operated effectively to improve the quality of the service; assess, monitor and mitigate the risks relating to people. People's records were not always accurate, complete or contemporaneous.