Waypoints Care Group Limited

Waypoints Verwood

Inspection report

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22 November 2017
27 November 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on the 20, 22 and 27 November 2017 and was unannounced .

The service is registered to provide accommodation and residential and nursing care for up to 42 older people. At the time of our inspection the service was providing residential care to 37 people most of whom were living with a dementia.

There was a registered manager in post. 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. The registered manager was absent at the time of inspection and temporary management arrangements were in place.

Waypoints Verwood is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. People were supported in a large purpose built home which was separated into four separate units spread over two floors. Each unit had a lounge area and there were two large communal lounge and dining areas on the ground floor. Access to the first floor was via lift or three staircases and there were accessible outside areas to the rear of the home and two first floor enclosed terraces.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

Risks people faced were not consistently monitored or actions taken when people's needs changed. We found that risks of people falling or developing pressure sores were not safely managed and this placed people at increased risk of harm.

People did not always receive safe care and treatment because there were not enough staff to meet their assessed needs. The service was using agency staff daily and this meant that staff did not always know people well.

Notifications of allegations of abuse were not sent to CQC and we identified and raised three safeguarding alerts to the local authority during our inspection.

People did not always receive their medicines as prescribed, this included issues with recording, times that medicines were given and incidences where people did not receive their medicines.

Fire checks were in place but there were not enough staff with sufficient fire training at weekends.

People did not always receive joined up care because the home didn't consistently work with external professionals.

People were supported in a purpose built building but there were some stained carpets and offensive odours in some areas of the home. There were plans in place to replace these.

Relatives told us that agency staff did not always communicate with, or know people very well.

Staff did not always use language which was respectful.

Concerns and complaints were not always responded to identify how the service could be improved.

People did not receive end of life care which was effectively planned and did not consistently include the views or wishes of relatives and those important to people.

Activities were varied and person centred but were restricted by the availability of activity staff with no-one covering weekends and one person during the week for 37 people.

Reviews were completed by staff but were not used as an opportunity to involve people or their loved ones in discussions or decisions about their care.

Audits and oversight were not comprehensive and did not always identify shortfalls in the requirements of the regulations being met.

Staff did not all feel valued or supported in their role and communication between staff and management was not effective.

Staff were recruited with appropriate pre-employment checks and received regular supervision and training in topics which were relevant for people living at the home.

People had assessments of their capacity and where needed, decisions were made in their best interests.

People had a choice of meals and were supported to eat safely with modified diets where required.

Permanent staff knew people well and interactions were kind and compassionate.

Relatives told us that they were able to visit when they chose and were welcomed.

During our inspection we found a number breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered providers to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's identified risks were not safely managed.

People were not consistently safeguarding from the risks of abuse..

People were not supported by sufficient numbers of staff to meet all of their assessed needs.

People did not consistently receive their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff provided care in people's best interests when they could not consent and decisions were generally recorded.

The service did not consistently work effectively with other organisations to provide person centred care to people.

People had a choice of food and were supported to eat and drink safely.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were supported by permanent staff who knew them well, however feedback about agency staff was not consistently positive.

Staff did not always use language which was respectful.

Relatives were able to visit whenever they chose.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Complaints received were recorded but were not consistently investigated or responded to.

People and their families were not involved in planning or making decisions about end of life care.

Activities were person centred but restricted by the availability of activity staff or additional time for care staff

Care plan documentation provided information about people's histories and what was important to them, but reviews did not consistently include people or those important to them.

Is the service well-led?

Inadequate

The service was not well led.

Systems in place to assess, monitor or manage the quality of the service provided to people were not adequate.

Staff did not all feel valued or supported in their role and communication between staff and the management team was not effective.

Notifications had not been made to CQC.

Waypoints Verwood

Detailed findings

Background to this inspection

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

The inspection was prompted by concerns shared with us about staffing and the standards of care at Waypoints Verwood. This inspection examined those concerns.

This inspection took place on 20, 22 and 27 November 2017 and was unannounced. The inspection was carried out by one inspector, accompanied by a specialist advisor with mental health experience and an expert by experience on the first day. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day of inspection the inspector was accompanied by a specialist advisor with nursing experience and the third day was undertaken only by the inspector.

Before the inspection we reviewed previous inspection reports. We had not requested that the provider complete a Provider Information Return(PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We collected this information during the inspection. In addition we looked at notifications which the service had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also spoke with local commissioners to obtain their views about the service.

During the inspection we spoke with two people who used the service and nine relatives. We also spoke with 19 members of staff, the nominated individual, director of operations, acting manager and acting head of care. We spoke with four professionals who had knowledge of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at a range of records during the inspection. These included 12 care records and four staff files.

We also looked at information relating to the management of the service including quality assurance audits, health and safety records, policies, risk assessments, meeting minutes and staff training records.

Following our inspection visit, we requested further documentation from the service. On 29 November 2017 we requested two copies of annual competency checks for staff which were provided. On 30 November 2017 we requested information about the investigations and outcomes of two complaints, and actions taken following the staff survey, we received a response to these queries. On 4 December 2017 we requested that the Nominated Individual investigate and provide assurances about the competencies of a member of staff, this was provided.

Inadequate

Is the service safe?

Our findings

People told us that there were not sufficient staff. One relative told us "sometimes at weekends they are really low on staff. There's not always someone on reception so it's difficult to get in". Another said "there are not enough staff and lots of agency staff". We observed one person who was assessed as requiring one to one staffing to keep them safe on their own on two occasions. This put the person at increased risk of falls or injury because they did not have the necessary level of observation to keep them safe.

Staff told us that there were not sufficient staff to meet people's needs. One member of staff said they, "used to spend more time with residents, quality time, but now we can only do the basics." Another member of staff told us about one day where there had not been enough staff available and explained that they, "made the decision because we were short staffed, that people were safer in their bedrooms". They explained that they had not had sufficient staff to support or monitor people and had therefore left some people in bed and done what they could to keep people safe. A further staff member told us "Today we have eight residents and two staff, six need help with feeding and all eight need help with personal care". They explained that staffing levels were not enough to provide the support that people needed.

We found that one person was recorded as falling and sustaining an injury to their head on 23 November 2017 at 7.10pm. Staffing rotas indicated that three staff were required to keep people safe. However between 4-8pm, only two staff had been working and the person had fallen during this time. Both staff had been on their way to support a person who required two to assist them at the time of the fall and there had therefore been no staff to observe or provide support for any other people on the unit during this time. We raised this as a safeguarding alert to the local authority.

The director of operations and acting manager told us that there was a senior on each unit during the day. Staff told us that there was rarely a senior on each unit. On our first day of inspection there was one senior staff member covering all four of the units and on our second day there were two seniors across all four units. Staff told us that there was always at least one senior working during the day but they were often covering more than one unit. This meant that there were limited staff available to provide advice and guidance for agency and other staff and that staff had to go to other units for guidance if no senior was available.

The director of operations told us that they were looking at a current ratio of one staff member to three people which they felt was sufficient. Some people had one to one staff in place which meant that 13 staff were required for each day shift at the home. Staffing rotas identified since 23 October there had been 11 shifts when staffing numbers had been below the level the provider had assessed as being required. The operations manager advised that recruitment was difficult and they needed 10 additional members of staff, mainly for day shift. Agency staff were used on a daily basis and on some units in the home, there were two agency staff and one permanent staff member.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks people faced were not safely monitored or managed which meant that people did not receive safe care.

People were not assisted to change position as assessed to manage the risks of developing pressure sores. Records indicated that people were not supported to change position in line with their risk assessments. For example, one person's care plan identified that they needed to be assisted to change position every two hours in the day. On 21 November the person had gaps of four and seven hours where they were laid in one position. One staff member said "I think (name) is turned every four hours, night and day. I don't know how often people need to be turned, someone tells me, usually the senior". The acting manager explained that they had identified that daily charts did not always tell staff how often people needed to be assisted to change position and highlighted this to the senior on duty. This meant that the risks to people's skin were not safely managed.

People were at risk of avoidable skin damage. Nine out of 10 pressure-relieving air-mattresses were set incorrectly according to the person's weight. A pressure mattress required by one person to prevent skin damage had broken. The person had been moved onto a standard mattress. The person was without adequate pressure relieving equipment for three days before they were moved back onto the correct mattress. The person developed a sore area of skin on their heel during this time. Another person was not laid on a pressure mattress as assessed. We reported this to the acting manager who was not aware of the potential harm that the person had been placed at. We also raised a safeguarding alert to the local authority. The acting manager informed us that the person had been moved onto the correct pressure mattress a day after we reported the concern..

On our second day of inspection we found that another person was not laid on a pressure mattress when this was an identified need in their care plan. It was not clear how long the person had been without the appropriate mattress. We reported this to the acting manager who was not aware of the potential harm that the person had been placed at. We also raised a safeguarding alert to the local authority. The acting manager informed us that the person had been moved onto the correct pressure mattress a day after we reported the concern.

Several people were identified as being at high risk of falls. One person had a number of unwitnessed falls. Health professionals had been involved and considered physical or medical causes of the falls. The person's risk assessment had been reviewed on 24 November 2017 but no changes had been made. Another person had fallen 14 times between September and October. Their care record showed that the persons' risk assessment had been reviewed on 24 October 2017 but no changes had been made. In both examples, consideration of other methods of minimising the risks of further falls had not been considered.

There was not enough equipment available which delayed people receiving the support they required to move safely. One staff member told us that they had requested additional equipment previously but this had not been provided and said it "can be a bit of a hunt to find equipment". We observed that a person on one unit needed to be hoisted. A staff member went off the unit to find a hoist and when they returned, the hoist had no battery. Staff searched for a battery which took further time before they could assist the person to move. On a different day of our inspection we saw that a staff member had to leave a unit to a find a hoist which had delayed the person receiving support for 15 minutes .We saw a record in a person's daily notes from 18 November 2017 which identified that a person was unable to be hoisted out of bed for their lunch because staff had been unable to find a hoist battery. Staff had contacted the on call manager but not received a response. The acting manager advised us that two further hoists would be purchased. We also observed the moving and assisting trainer installing signs in people's rooms during our inspection to indicate which hoist and sling each person required so that staff had access to the information about how to

move people safely.

People did not receive their medicines as prescribed. We looked at the Medicine Administration Records (MAR) for all 37 people in the home and found that there were 30 recording errors. These included medicines not being signed for, times of administration not recorded where a medicine was time specific and some medicines being given after breakfast when the prescription detailed should be administered 'on an empty stomach'. Some people had medicines which were prescribed 'as required'. There was no guidance in place for four people to determine when these medicines should be administered.

The service had a medicines policy in place but this had several omissions around the administration of certain types of medicines. Where people were prescribed pain relief, there were no pain monitoring tools in use. This meant that if people were not able to verbally express that they were in pain, staff had no clear direction about assessing whether pain relief was required or not. This was relevant because the majority of people living at the home had advanced dementia and may not have been able to verbally communicate their needs to staff.

Some people had prescribed creams which staff applied. There were gaps in the recording about when these creams had been applied with some being applied most days but others nor being administered. For example, several people had a prescribed shampoo which was required to be administered twice weekly. Two of these people had only had this shampoo once in November 2017 and another person had only had this shampoo twice in November. The person was not able to speak with us but their loved one explained that they had been scratching their head indicating that their head was itchy and this was not comfortable for them.

Fire safety measures were not consistently up to date. Staff told us that they had regular fire drills and we saw that there were regular checks of fire safety including emergency exits, fire alarms and emergency lighting. The location had a fire risk assessment and person fire evacuation plans for people. Some staff had fire marshal training and were responsible for managing staff and evacuation procedures in the event of a fire. We identified that no-one with this training worked at the weekends and spoke with the director of operations about this. They assured us that other staff had this training but then confirmed that only three staff were trained in this role and weekend cover was not in place. They told us that they would look to train more staff to ensure that this responsibility was met.

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

People were not protected from the risks of abuse because systems were not embedded to identify or report concerns to the local authority adult safeguarding team and to CQC. This meant that lessons were not always learned from incidents or concerns because these were not consistently raised or discussed with the staff team. We raised three safeguarding alerts during our inspection.

Staff were able to tell us about the types of abuse that they would be aware of when supporting people. These included more subtle changes in people's behaviour or facial expressions. Staff were told to report any concerns to the home manager and to complete a paper document of their concerns but were not clear about whether this meant that the concerns they raised were investigated. This meant that any learning from safeguarding incidents was not always shared with staff to enable them to learn and improve practice to prevent other potential abuse or incidents.

People were supported by staff who were recruited safely with appropriate pre-employment checks. These

checks included seeking references from previous employers and carrying out disclosure and barring service (DBS) checks. The DBS checks people's criminal record history and their suitability to work with vulnerable people.

People were protected from the risks of infection because there were adequate checks of infection control in place. Staff had access to appropriate Personal Protective Equipment (PPE) to support people and we saw these being used by staff throughout the inspection. People had individual slings and slide sheets in their rooms to assist them to move. This reduced the risks of cross contamination as they were solely for use by one person. There was an infection control policy in place which provided guidance for staff. Housekeeping staff were clear about their role in ensuring the home was clean and hygienic for people.

Requires Improvement

Is the service effective?

Our findings

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 had assessments of their capacity in place with regard to different decisions about their care and treatment. For example, one person could become upset and present a risk to themselves or other people and staff. They had a capacity assessment in place and a best interests decision had been made regarding how to support the person. This had involved the person's relatives and considered the least restrictive options.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The provider did not act in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards because they had not met the conditions attached to the DoLS authorisations for two people. Both people had conditions attached to their authorisations which required them to be regularly supported to go out into the community. Suggestions including going for walks, accessing the grounds outside the home or accessing local coffee shops were documented in the DoLS authorisations. Activities records from August to November 2017 showed that one person had not been out at all during this time and the other person had been out three times over the four month period. Staff were not aware that either of these people had conditions attached to their DoLS and the director of operations and acting manager were not aware that these conditions had not been met.

Some people had applications for DoLS which had been made to the local authority and were awaiting consideration. There was a summary sheet available which provided details about when applications had been made and when any authorised DoLS expired to trigger a new application to be made. This was not up to date, but applications had been made appropriately when required. The acting manager told us that this was in the process of being updated.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Registered nursing staff at the service needed to maintain their professional registration with the Nursing and Midwifery Council (NMC). The acting head of care told us that it was their responsibility to ensure that any newly qualified nursing staff received the appropriate support to learn and develop in their professional role. They explained that they had a newly qualified trained nurse working at the service and would be ensuring that they received the necessary support. Although this support was planned, it was not currently

in place and there were no clear systems to support other trained nursing staff when they needed to update their registration with the NMC.

The service did not consistently work effectively with other organisations to provide person centred care to people. One professional told us that they had visited unannounced to visit a person and had been refused entrance by a member of the management team because they had not made an appointment. On another visit, the professional told us that the member of the management team "didn't know much about (name)". Another professional told us that they had tried to encourage the service to engage with them on several occasions but said "the service haven't made contact to update us about people".

People were supported in an environment which had been purpose built to enable them to have space to walk around and a relative told us this was a positive for their loved one. However some of the carpets were heavily stained and there were some offensive odours in some areas of the home. One relative told us "Sometimes walking round the corridors it can be smelly". There were plans to replace the carpets. Although the home was split into four units with bedrooms on each, people were only able to access the spaces on their floor of the home without support. The home had clear signage on the bathrooms and other communal areas to assist people who had a dementia to find different areas of the home. There were accessible, secure outside spaces people could use in warmer weather and these had seating and viewpoints for people to see into the surrounding woodland. The home also had a sensory room which people were supported to access with the activities co-ordinator, but could also be used by relatives if they wanted a quiet space to spend time with their relatives.

Assessments were completed with people before they moved into the home and these included details about what support they required and information about key contacts and medical histories. People's records showed that there was contact with some health professionals including people's GP's.

New staff received an induction into their role and were supported to complete the Care Certificate. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. If staff had previous experience in health and social care, the training manager advised that they checked competencies in the same areas as the care certificate to ensure that they had the correct knowledge for the role. Staff completed face to face training in moving and assisting people and positive behaviour management techniques before completing some shadow shifts with other staff. Staff told us that they had worked on each unit and observed practice which assisted them to get to know people living in the home. Staff told us that their induction had been positive and they had spent time shadowing and were observed in areas of their practice including communicating effectively with people and assisting people to move safely. Agency staff were taken through an induction checklist by staff which included fire procedures, codes to access different areas of the home and an introduction to other staff and orientation of the home.

Staff received training in some areas which the service considered mandatory. These included health and safety, infection control and safeguarding. The training manager told us that some staff had additional training in areas including first aid, diabetes and dignity. They also completed competency checks of each of the 15 standards set out in the Care Certificate annually with staff to ensure that they had the required understanding and skills to carry out their role. Where agency staff were used, the service received profiles which included training and experience.

Staff told us that they received regular supervision and there was a supervision structure in place. Supervision for the management team was provided by the operations manager and other staff were supported by the acting manager and acting head of care. Supervision records indicated that staff were able to discuss practice and any concerns or issues that they had but these were not always listened to. For

example, a supervision record for one person indicated that they did not feel comfortable working on shifts with only agency staff as they would then have the responsibility for ensuring that agency staff knew what was required and recorded effectively. However this staff member was on shift with two agency staff during our inspection. We spoke with the staff member who explained why they had expressed this view but acknowledged "I don't think they(management) have a choice because of staffing levels."

People were supported to have sufficient to eat and drink and where people needed assistance to be able to eat safely, this was provided. Several relatives of people visited regularly and assisted their loved ones with their meals which reduced the number of people staff needed to assist with meals. Food and fluid charts were in place for some people and these were generally completed. People had a choice of meals and senior staff offered people choices each day and passed this information to the kitchen. The chef was competently able to tell us about people's dietary needs and knew which people required a softer diet to be able to eat safely. Some people at the service were vegetarian and this was understood and respected by the chef who ensured that there was a vegetarian option available. They also told us that they would make something different if the vegetarian option was not wanted. We observed a person being shown both of the meals available so that they could choose which option they wanted. The chef explained that they were in the process of developing visual menu's so that people were able to see what the options looked like and would be better enabled to identify their preference. This was important because a lot of people at the home had an advanced dementia and may not have been able to make verbal choices about meal options.

Where people exhibited behaviours which could challenge and put themselves or others at risk there were risk assessments in place which gave details about possible triggers for people becoming upset and actions which could help to calm them. For example, one person could become upset by being in a busy environment and distraction techniques including offering drinks, listening to music or engaging with different staff could help to reassure them. Where another person was observed as upset, we saw staff providing tactile contact and distraction in the ways described in their care plan. Staff told us that they did not use restraint with anyone in the home, but there were plans in place for when these techniques might have been required and staff received training in crisis intervention and breakaway techniques.

Requires Improvement

Is the service caring?

Our findings

Relatives told us that there were always agency staff working when they visited. Several commented that agency staff did not always listen or know their loved one well. One relative explained "usually there are lots of agency and they don't know people very well" and another told us there were "lots of agency….if I want to know how (name) is I have to find a permanent staff". Another explained "The agency staff are not so knowing with the residents". A professional advised that their experience of staff had been that conversations with permanent staff were very good but "very poor and at time non-existent from agency staff". They gave an example of when the relative of the person they were visiting raised concerns with an agency staff member, their concerns were ignored. Another relative explained that when they had spoken with an agency member of staff about a concern, their response had been "I'm agency….You can't expect it to be perfect". A staff member told us "we have a mix of agency staff…some are very good and some I worry about". This meant that people were not always supported by staff who understood their preferences for care and treatment and interactions were sometimes poor.

Language used by staff was not always respectful and we heard several members of staff refer to people who needed assistance to eat as 'feeders'. The culture at the home was that this use of language was acceptable and we observed this used by the majority of staff. As also heard staff referring to people who required two staff to assist them as 'doubles'. One staff member spoke with us about staffing levels and said "they (people) are mostly doubles and need extra staff when the feeds need to be done". Another told us "there are a lot more doubles now".

Staff understood how to provide support to people in ways which protected their privacy. We saw staff closing doors when they were providing people with intimate care and explaining how they ensured that people's dignity was respected. One staff member explained that they ensured that people's curtains and doors were closed to protect people's privacy and that they covered people with towels when assisting them to respect their dignity.

Relatives all told us that the permanent staff were caring and compassionate and did their best for the people they supported. Comments included "I watch and see what's happening…the staff really care". "Most of the staff are lovely and I appreciate what they do". We observed one person who was becoming upset, staff were in the communal lounge with the person and immediately went to reassure them. They understood the possible triggers for the person becoming upset and how to interact with the person. They offered the person a drink and used tactile contact which we observed had a calming impact.

People were supported to communicate with staff in ways which were meaningful to them. One person had limited verbal communication and had previously spoken another language in additional to English. Two staff members also spoke this language and one told us how they spent time speaking in both languages to try to promote communication in a way the person was able to understand. The activities person explained that they also played music from the person's native country to them and that the person had smiled when they heard this.

Relatives told us that they were able to visit whenever they chose and we observed that several relatives visited the home daily. Two relatives told us that staffing was often lowest at weekends and this sometimes made it difficult to get in to the home because reception staff were not always at their desk and were therefore not able to let them in. The provider informed us that there was a doorbell to which staff responded if reception staff were not at their desk.

Requires Improvement

Is the service responsive?

Our findings

The provider had not followed their own complaints procedure as complaints had not all been investigated or responded to within the timescales set by the complaints policy. Two complaints which had been received in July 2017 and letters had been sent to the complainants advising that their complaint had been received and that concerns would be investigated and responded to within 28 days. One complaint had not been responded to until it had been chased by the complainant in October 2017 and they then received a written response dated 3 November 2017, nearly four months after the original complaint had been received.

The second complaint had raised concerns about a member of staff. The director of operations was unable to provide any evidence that the complaint had been investigated or that any actions required had been identified or acted upon. The director of operations told us that the registered manager may have this information but was not at work during the inspection and was not provided.

There was an audit in place around complaints which detailed the dates they had been received, when complaints had been acknowledged, what actions had been taken and whether complaints had been resolved. However this was not up to date and did not identify any actions taken in respect of the two complaints we had highlighted. There was a complaints policy in place which gave contacts for outside agencies including the local authority and clinical commissioning group. Relatives told us that they would be confident to raise any complaints with the management team if needed.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans did not show involvement of people or their relatives and did not include actions taken as a result of monthly reviews. For example, one person's care plan around their mobility had been reviewed in November and stated that the person had one to one support during the day to assist the person. However the person also had a risk assessment in place which had also been reviewed on the same date and stated that the one to one provision was no longer in place. It was not clear when this had stopped or what changes had been made to the person's care as a result of this change. Care plan documentation was reviewed by staff but did not include people's views or those of relatives or involved professionals. A staff member explained that the process in place was to review the care plans and then involve people and their families to discuss the support and be involved in any changes to the person's care and treatment. However they explained that in practice, this did not happen and care plans were routinely reviewed purely by updating the care plan. One relative told us "they haven't invited me to any reviews relating to (name)".

Care plans provided information about people's histories and what was important to them. This included whether people had a preference for male or female staff and whether they had a preferred name they wished to be called by. We saw that these preferences were respected by staff.

People and relatives were not actively involved in making decisions about the care and treatment they

received or kept up to date about changes to people's needs or support. Staff did not always have time to speak with relatives and we heard of several incidences where actions had not been taken when issues had been raised with staff. One relative explained that their loved one had not been able to have a shower for some time. They had raised this with staff but the issue had not been resolved. One relative told us that they had not been told about any incidences of their loved one behaving in a way which was challenging. However we saw that there had been an incident of this behaviour occurring in July 2017. Another relative had attended a review for their loved one which had been arranged by the local authority. The home had agreed to trial a new piece of equipment with a person. However the relative then had to chase this and it was finally trialled three months later.

People and their families were not involved in planning or making decisions about end of life care. People had end of life care plans in place but these did not include discussions about people's wishes or preferences of those important to people. We looked at eight end of life care plans and found that seven of these identified the need to discuss end of life wishes with people and their relatives and others important to them. There was an end of life policy in place which stated that an end of life care plan was expected to 'ensure that the residents' wishes in respect of their religious or cultural practices are fully respected' and that 'the home makes every effort to ascertain them (the person's wishes) from relatives, friends and professionals who know the person'. This was important because many people at the home had advanced dementia and were unable to express their wishes about their end of life choices, if loved ones were not involved then there were no clear plans in place to ensure that people would receive person centred, individual end of life care which was respectful of their choices and wishes.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not have sufficient opportunities for social interaction at the service. There was an activities co-ordinator in post who worked full time however there was no provision for weekend opportunities for people and because the majority of people had an advances dementia, a large number preferred one to one time with staff and opportunities which were meaningful for them.

Staff were not able to regularly engage people in social opportunities because they did not have sufficient time to do so. A relative told us that the activities co-ordinator "tries their best but there is only one of them….I worry whether (name) is getting what they need. Often I arrive and (name) is sat staring into space". Another commented "they do quite a lot of activities for them but they are not suitable for (name)". Another explained "(name) doesn't want to be just sat in this chair in their room. They need to see other people and have interaction".

The activities co-ordinator knew peoples preferences and interests extremely well and used innovative ideas to try to engage people. We observed them trying out a board game on an electronic tablet for the first time and saw that the person was engaged in the one to one activity. The activities co-ordinator also used the tablet to spend time with a person using a virtual fish pond. They explained that the person used to enjoy fishing and this enabled them to see and hear the familiar sounds and pictures and engage with them.

Inadequate

Is the service well-led?

Our findings

The provider had not ensured that there were adequate systems in place to assess, monitor or manage the quality of the service provided to people. The management of the home had undergone significant changes over the last year which had led to changes in the registered manager and head of care roles. There was a registered manager in post who staff spoke positively about. However they were absent at the time of inspection. The head of care had been recruited in September but was acting up as the manager at the time of inspection and one of the trained nurses was acting up as the head of care. A registered manager from another service had been providing some management support alongside the director of operations. The governance of the service was not effective or robust and this was evidenced by the gaps in oversight and lack of clarity from the provider about their roles and responsibilities.

We spoke with the provider about a safeguarding alert raised in July 2017 which related to concerns about an agency member of staff and their competence to administer medicines. We identified that the staff member was on the staff rota in October and November and sought information from the provider about how they had assured themselves of the competence of this member of staff. The Nominated Individual investigated and responded to our request. They were unable to provide any evidence that the concerns had been reported to the agency who employed the member of staff, or that the provider had completed any checks to assure themselves of the member of staffs competence. Following our request for this to be investigated and responded to, the provider provided assurances that the concerns had been reported to the agency and the staff member was no longer working at Waypoints Verwood. This outcome was five months after the original safeguarding alert had been raised and meant that the provider did not have established, effective systems in place to ensure that risks to people were assessed, monitored or mitigated.

Quality assurance measures did not identify gaps or trends or take actions from these. Some areas of the service did not have any oversight systems in place to monitor standards or drive improvements. There were no regular observational checks by staff on people who received support. Very few people were able to use their call bells to summon attention which meant that they were dependent on staff physically checking on their wellbeing.

People were monitored only when staff needed to assist them with meals or drinks, to change position or with personal care. The director of operations explained that people were monitored throughout the day as staff go about their duties, we observed this to be the case. However, there was no effective system in place to ensure adequate monitoring of people to ensure that all of their identified care and support needs were met.

Staff did not feel supported or valued in their role and told us that communication with management was not effective. There were daily handovers and catch up meetings with the senior staff. Communication was also sent through an electronic system and the management team had an open door policy. However we frequently found that management were not aware about situations within the home and although staff communicated well on shift, there was a communication breakdown between staff and the management team. One staff member told us "communication here is diabolical…I find it quite frustrating". We spoke

with them about someone who had fallen while being assisted to move. They told us "I would hope I would have been informed" but this had not happened. Another staff member discussed an issue they were concerned about with us and said "we have not been well consulted….I've only been asked once". Another explained "you aren't asked…just told what to do". A professional told us that two staff had told them that did not feel valued and they observed that trained staff were under enormous pressure. The acting manager told us the main challenge at the home was "pulling everyone to work together as a team….I can't pin point what the issue is". The provider told us about what they had done to value staff. These included use of an employee of the month award and giving staff gifts on their nationally recognised work days. For example, nurses day and during carers week.'

Resources were not always available to develop and improve the service people received. Minutes from a senior meeting on 1 November 2017 stated "our chart documentation is weak". Previous monitoring visits by the local authority and clinical commissioning group had also identified issues with care plan recording in September 2017. This meant the provider was aware of some of the areas for development. The provider explained that training in recording and reporting had been provided for staff in response to some of the areas highlighted. They acknowledged that there were still significant improvements to be made. One staff member told us that they had been told to complete additional work around recording during our inspection but had not felt that had the skills required to do this and was not given any additional time to complete the work.

Feedback from staff was not always acted upon and surveys responses indicated staff were not all happy in their roles. Staff surveys were completed every 6 months and the last survey completed in August and September 2017 had been returned by 17 staff. The provider advised that this represented 20% of the total staff team. Over 50% of responses highlighted that staff either disagreed or strongly disagreed that meetings were useful and proactive and that staff were involved in future plans about the home. 54% of staff responded positively about communication in the home, however 10 staff disagreed or strongly disagreed that their views were asked for. Feedback from the surveys relating to pay and recognition had been acted upon and the provider explained that rates of pay had been increased in response to this.

Some staff also responded negatively about job satisfaction in their roles. Eight staff did not feel that Waypoints Verwood was a great home to work for and nine didn't feel that the home met their expectations as an employee. 10 staff disagreed that they would recommend Waypoints Verwood as a great place to work. Some staff made comments about this including 'overall a great place to work, however communication needs to be improved', 'very little training at (Waypoints)Verwood' and a staff suggestion for the service to consider rewards to 'encourage them(staff) to stay'. Another comment explained 'although lots of meetings are held, the employee's voices are heard but never acted upon'. A staff member told us "it would be nice to hear thank you for all your hard work". Another explained the "management team don't always understand about staffing levels".

Staff were not able to take their breaks consistently. Different members of the inspection team observed that some staff did not have a break for their lunch until after 2pm and some staff did not get their lunch break until around 4pm. Staff comments included "morning and lunch breaks are usually able to be taken, afternoon breaks not always possible", "we don't always get breaks" , "often my lunch is 4pm". This meant that staff were working for extended periods without the required employment breaks, this added to the pressure and stress that staff were under and may have been a contributory factor in the high sickness rates reported by the acting manager. The provider had tried to address this with staff through email communication and reminders but at the time of inspection this was still found to be an issue.

The operations manager and acting manager told us that staff were taking their breaks but suggested some

staff were not as good at managing their time and were slower at completing their duties.

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

The provider had failed to notify CQC about safeguarding allegations. This is a requirement of the provider's and registered manager's registration so that where needed, CQC can take follow-up action. There had been 24 allegations of abuse raised to the local authority between 6 June and 20 November 2017. None of these had been reported to CQC. The acting manager and operations managers were not aware of the regulatory requirement to report allegations of abuse to CQC.

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

Management had created new roles for medication administrators. The roles were created to improve the accuracy of medicines. We were informed that four staff had been recruited and were to receive training to become medication administrators. Three of these staff already worked at the home so vacancies had been left in their previous roles as care staff, but recruitment was planned to replace them. The job description for this role was in draft at the time of inspection. The acting manager advised that they were 'heavily involved in ensuring that everything was put in place for the new role. The plan was to reduce the trained nursing staff from two to one during the day because trained nurses would no longer be responsible for administering people's medicines. Two trained staff told us that they had not been consulted about this new role and how it would affect their professional registration because the existing trained staff would be required to sign off the medicines which were administered by the new medical administrators. The provider informed us this was not the case and that trained staff had been consulted about the changes. The acting head of care told us that they were investigating national guidance to ensure that trained staff received the professional support required.

To provide extra cover whilst recruiting a new Head of Care, the service had created a new quality assessor role for a 3 month period ending on 30 November 2017 to focus on ensuring oversight of the support people received. Feedback was that this new role had been positive, however the staff member in this post had been recruited to one of the new medical administrator roles and the quality assessor role was therefore not filled at the time of the inspection.

Some staff comments had been acted upon. A request had been made for additional housekeeping equipment and staff told us that this had been provided, although with a delay. Other comments were positive including 'love where I work. Kind and friendly staff. I am always thanked at the end of my shift by everyone'. 12 of the staff who responded to the survey agreed that they could ask for advice and support from their manager and were positive when asked 'I know what is expected of me and do a good job'.

The provider had used information from the recent inspection of one of their other homes to improve their oversight by drafting a company governance chart to identify clear responsibilities for each area of oversight for the home. This was in progress at the time of inspection. There was also a new 'good governance' policy in draft which outlined that the provider would be responsible for ensuring regular audits were completed and that the operations manager would utilise 'an appropriate audit tool' to evidence that the service was meeting the CQC key lines of enquiry of safe, effective, caring, responsive and well led. The purpose states that 'as a provider…..we recognise our responsibilities to ensure compliance'. The introduction of this framework was positive and demonstrated that the provider had learnt from the inspection at the other service, but as it was not yet in place, it was not clear how the provider was currently able to assure themselves about the regulatory compliance of Waypoints Verwood.

The provider attended quality improvement meetings with the local authority and clinical commissioning group to improve partnership working and identify and work on improvements at the home. These meetings were also attended by other external professionals and promoted a joined up approach to improvements. The provider was open and honest about improvements which had been identified as part of monitoring visits from other agencies and they were transparent by sharing the initial feedback we provided following our inspection with the local authority and clinical commissioning group.

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 The provider did not notify CQC of allegations of abuse in relation to people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People and those important to them were not involved or enabled to make decisions about their care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not operated an effective system to handle or respond to complaints by service users and other personsl.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not ensured that the risks people faced were safely managed or that people received their medicines as prescribed.

The enforcement action we took:

We imposed conditions on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider did not have effective systems in place to assess, monitor or improve the quality and safety of the services people received and did not consistently act on feedback received.

The enforcement action we took:

We imposed conditions on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The provider had not ensured that sufficient numbers of suitably competent, skilled staff were deployed in order to meet people's assessed needs

The enforcement action we took:

We imposed conditions on the providers registration