Watermoor House RCH

Watermoor House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Watermoor House is a residential care home providing accommodation and personal care for up to 39 older people and people living with dementia in one adapted building which has a range of communal areas, an external courtyard and outdoor areas people can use. At the time of the inspection, 25 people were living in the home.

People's experience of using this service and what we found

We found some improvements were still needed to ensure safe recruitment practices were followed and to the provider's quality monitoring systems and processes . Not all staff understood people's risks and how to keep them safe. People's care records were not always reflective and up to date with this information.

The provider's audits were not always effective in identifying and addressing quality and safety concerns in staff recruitment and care records.

We did not find that these shortfalls had impacted people's care. The new manager had recently started, and prior to our inspection, identified the action required to ensure improvements were made.
People told us they felt content living at Watermoor House. People's relatives were complimentary about the care their loved ones received. Staff spoke positively about the leadership of the home and the new home manager.

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

People were supported to receive their prescribed medicines safely.

People were supported by staff trained to meet their needs.

The service had infection control processes and systems to reduce the risk of people contracting COVID-19.

Managers promoted a culture that enabled people, their representatives and staff to feel comfortable giving feedback, raising a concern or, where needed, making a complaint.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 01 November 2022), and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they

would do and by when to improve. At this inspection, we found that not enough improvements had been made, and the provider remained in breach of regulations.

Why we inspected
This inspection was prompted by a review of the information we held about this service and to verify if the provider made enough improvement in relation to previous breaches of regulations.

The inspection was also prompted in part by notification of an incident following which a person using the service died. This incident was subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of the risk of falls. This inspection examined those risks.

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

We used the ratings awarded at the last inspection for those key questions not inspected to calculate the overall rating. This is based on the findings of this inspection.

The overall rating for the service has remained requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

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

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

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

We have identified breaches of regulations in relation to people's risk management, safe recruitment, and good governance at this inspection. Please see the action we have told the provider to take at the end of this report.

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

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Watermoor House

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by 2 inspectors and 2 Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection, there was no registered manager in post. The service had recruited a new manager who had started their role the week prior to our inspection and was planning to become registered with CQC.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We observed staff interacting with people and looked at the premises. We spoke with 18 members of staff, including the nominated individual, the home manager, the deputy manager, the recruitment manager, the training coordinator, the chef, the activities lead, the dementia link, a team leader, a senior carer, the housekeeping lead, 2 housekeepers, the maintenance person and 4 care staff. We also spoke with 16 people using the service, a healthcare professional who visits the service on a regular basis and 10 people's relatives.

The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 5 people's care records and records related to medicines. We looked at 4 staff files in relation to recruitment. A variety of records relating to the management of the service, including audits and safety checks were reviewed.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment
At our last inspection the provider had failed to follow safe recruitment practices. This was a breach of regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19.

- Procedures were not followed when new staff were recruited to ensure they were safe to provide care to people. Reference checks from previous social care employers were not always sought to gather assurances about staff conduct and to verify the reason for leaving their employment.
- The provider's recruitment policy did not reflect safe recruitment processes as required in health and social care.
- Interview records were in place to support the provider's decisions to employ staff. Since the last inspection, the providerintroduced a system to gain information about gaps in employment histories. However, this had not been effective.
- Records did not show how the provider had assessed the risk to people when they were unable to obtain references or complete checks on an applicant's employment history. This meant additional safeguards were not in place to ensure staff were of good character.

Safe recruitment practices had not always been followed. This placed people at risk of harm. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Checks with the Disclosure and Barring Service (DBS) had been completed. These checks provide information including details about convictions and cautions held on the Police National Computer. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable people.
- The provider and home manager are working in a sector with significant workforce challenges. Recruitment was ongoing to fill staff vacancies. In the interim, the provider was looking at using consistent agency staff to maintain the assessed staffing levels, and existing staff worked additional hours.
- The deputy manager told us the service had a system in place to calculate the required staffing levels and that there were enough staff to support the current number of people living at Watermoor House.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● The provider had systems in place to identify, assess and mitigate people's risks. However, these had not always been followed.
● Risk management plans for people experiencing seizures did not provide detailed information about the actions staff should take if people were to become unwell. There was no clear care plan to provide staff with information. Not all staff were able to describe the actions they should take if they were required to support a person experiencing a seizure. This puts people at risk of not receiving the appropriate care.
● One person had been prescribed thickener for their drinks to support them to drink safely. Not all staff were able to describe how they would safely prepare the drinks. There was no clear information in the person's care plan explaining how staff should prepare the drink as per the prescribed amount. This put people at risk of not receiving safe hydration.
● The provider had systems in place for staff to report and record any accidents and/or incidents.
● These were reviewed to ensure the provider's policy was followed. However, the level of scrutiny used to review the accidents and incidents had not been maintained in the recent months leading up to our inspection, which meant that actions were not always clearly identified and recorded.

Effective systems had not been fully implemented to assess and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The new home manager had identified through their appraisal of the service that people's care documentation required updating and prioritised this on their action plan.
● Environmental risks to people were managed safely. Risk assessments and safety checks had been carried out to reduce the risk of fire and legionella.

Systems and processes to safeguard people from the risk of abuse
● The provider had procedures in place to respond and safeguard people from abuse.
● People were protected from the risk of abuse by staff who knew and understood the provider's safeguarding policies and procedures. Staff described the arrangements for reporting any concerns relating to people using the service and were confident to do this.
● People were very pleased with the home and the care they received. People's relatives told us their loved ones felt safe living in the home. One person told us: " There is a nice atmosphere, people are kind."
● Comments from relatives included: "I know [person] is safe in their care, I have no doubt I am absolutely sure" and "[person] is very safe there; they do look after [person]."

Using medicines safely
● People received their medicines safely as prescribed.
● Appropriate arrangements were in place for obtaining medicines. Medicines were kept safe in a locked medicine trolley stored in a designated medicine room.
● Staff responsible for administering medicines received training and competency assessments to ensure they had the skills to administer medicines safely.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
● The provider ensured Deprivation of Liberty Safeguards (DoLS) were applied for people whose liberties were being restricted. DoLS applications had been supported by mental capacity assessments and best interest assessments.
● Staff had received training in mental capacity and deprivation of liberty safeguards.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

People were supported to see their families and friends in accordance with their preferences and in line with government guidance.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centered care.

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

At our last inspection, the provider had failed to have robust systems that demonstrated people's safety was effectively managed.Accurate, complete and contemporaneous records in respect of each person's care were not always maintained. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The provider had a recruitment policy in place; however, this was not always followed and was not fully reflective of safe recruitment requirements.
- Since our last inspection, the provider had introduced a new system in relation to safe recruitment practices. However, these had not been effective in ensuring staff were recruited as per the regulations. The provider had not identified through its own monitoring systems that all required checks had not been completed before the service offered an applicant employment.
- People's care records were being audited, and there was evidence that these had been recently reviewed; however, these systems were not always effective in ensuring people's records reflected their care needs.
- One person who was at risk of choking and had been assessed by a Speech and Language Therapist, staff could describe how to support them to eat safely. However, this person's choking risk management plan was not up to date to ensure staff had current information about the person's safe food preferences to refer to.
- For a person who had experienced several recent falls, there was no information in the care documentation in relation to risk reduction measures implemented. This meant that staff might not have all the necessary information to support the person safely.
- The provider had not operated effective systems to ensure people's individual needs had been assessed. Additionally, there were not always effective systems in place to ensure that people's care assessments were reviewed following incidents and accidents to reduce the risk of avoidable harm.

The provider did not always operate effective systems to monitor, assess and improve the quality of service

they provided. Accurate, complete and contemporaneous records in respect of each person's risks were not always maintained. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service did not have a registered manager in place. However, a new home manager started the week before our inspection. People met the new home manager and told us: "I have met the new manager and have heard good reports of [home manager]" and "The new manager seems very good, [home manager] came round to talk to people."
● Since our last inspection, the provider had introduced a system to monitor daily records showing that staff had implemented people's risk management plans so that the manager could determine whether people's risk plans remained effective.
● The new home manager had started an action plan to improve the service following the initial appraisal of the service. They were supported with this by the nominated individual and the board of trustees.
● The trustees and nominated individual were visiting the home regularly and engaging with people and staff. They were kept updated about the running of the home through monthly reports produced by the management team.

Promoting a positive culture that is person-centered, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● People and their relatives spoke positively about the staffing team and the caring approach.
● People told us: "The staff are good and kind and try to do their best"; "I appreciate what the staff do for me, they do what is necessary very well" and "The care is very good, staff know what I like."
● People's relatives told us: " they are very well looked after"; "I am extremely happy I have good rapport with the nursing staff" and "they are fantastically caring, helpful and friendly, they really are considering the problems they are up against. I think they do really well"
● The home manager was fully aware of their legal responsibility to notify CQC of notifiable events. The provider understood their responsibility to be open and honest when an incident had occurred.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The service held staff meetings periodically and handovers were taking place twice a day. Daily flash meetings were organised with department leads.
● Staff told us they felt supported, listened to and able to provide feedback.
● The provider had a system in place to gather feedback from staff, people and their relatives. Newsletters were produced regularly for staff and people.
● People were assigned key workers which were engaging with people for regular catch ups and monthly reviews. One relative told us: "the key worker makes herself known to you and gets you involved in the care plan."
● People's relatives were complimentary about the atmosphere of the home. Comments included: "It's a family type atmosphere", "They have created a family I think they have achieved that it is very friendly and warm" and "It is welcoming, caring, friendly and committed to looking after people in their care."

Working in partnership with others
● The service worked openly and in partnership with others, such as the GPs and district nurses.
● We have received positive feedback about the service from one healthcare professional working with the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Effective systems had not been fully implemented to assess and mitigate risks to the health, safety and welfare of people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always operate effective systems to monitor, assess and improve their service quality. Accurate, complete and contemporaneous records in respect of each person's risks were not always maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment practices had not always been followed.