Minster Care Management Limited

Waterside Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Waterside Care Centre is registered to provide nursing and personal care for up to 47 people. This is a purpose-built home where care and support are provided for people aged 65 and over, this includes people living with dementia. At the time of the inspection 42 people were living at the home.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

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

Right Support:
People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

Right Care:
People were supported to access health care appointments. Care was not always person-centred and did not always promote people's dignity, privacy and human rights. The provider had not always taken the necessary steps to ensure people were safe.

Right Culture:
Staff did not always have the training or understanding necessary to carry out their roles effectively. The environment and culture did not promote empowerment for the people that lived in the home.

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

Rating at last inspection
The last rating for this service was good (published 17 December 2019).

Why we inspected
The inspection was prompted in part due to concerns received about the care and lack of opportunity for people at Waterside. A decision was made for us to inspect and examine 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
The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements.

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 Waterside Care Centre Name of location on our website at www.cqc.org.uk.

Enforcement and Recommendations

We have identified breaches in relation to safe care, personalised care, staff training and governance at this inspection.
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.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Waterside Care Centre

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 team consisted of 3 inspectors, 1 specialist nurse advisor and an Expert by Experience who made phone calls to relatives. 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
Waterside Care Centre 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. Waterside Care Centre is a care home with 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 a registered manager in post.

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 sought feedback from the local authority and professionals who work with the service. 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 spoke with 4 people who used the service and 4 people's relatives to gain their feedback about the service. We spoke with 10 staff including the registered manager, area manager, nurses, care staff, maintenance and the kitchen staff. We reviewed a range of records. This included 5 people's care records, samples of medicine records, daily records and care plans and risk assessments. We looked at 3 staff records and a variety of records relating to the management of the service, including audits and procedures. 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.

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 good. At this inspection the rating has changed to 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.

Assessing risk, safety monitoring and management, Using medicines safely

- Environmental risks associated with people's care and support had not been assessed or mitigated. This left people at risk of significant injury.
- We found two window restrictors that were in place to stop people from falling from a first floor window were damaged. Cable was exposed and the structural integrity of the window restrictors was compromised increasing the risk of serious injury.
- We also found other window restrictors were not fitted in accordance with regulation, meaning they were not fit for purpose. We raised this with the registered manager and maintenance and instructed that they needed replacing as a matter of urgency. However, when we returned for the second day of inspection 5 days later we found the window restrictors were still not meeting the required standards for safety.
- We identified that wardrobes were not secured to the walls in people's bedrooms. This could result in heavy furniture falling on people and left people at risk of significant injury.
- In the kitchen we found loose food products which were not decanted into sealed airtight labelled containers or dated as to when these products would expire. We also saw containers storing food products were visibly dirty. We were told the loose products within these containers were used in food preparation. This increased the risk service users could experience ill health.
- Risks associated with people's specific health conditions did not contain accurate information for staff to follow. For example, one person had a diagnosis of epilepsy. The description of the seizures in the epilepsy management plan did not match what staff told us about how the persons seizures currently presented. What staff told us would have required a different response to what was in the management plan. Staff told us there was no other care plans or risk assessments regarding this person's epilepsy. This left the person at risk of receiving treatment that was not appropriate to their specific health needs.
- Care records did not always contain the information to assess and manage the risks associated with the administration of medicines. For example, some people were prescribed PRN (as required) medicines to be given when they were experiencing increased anxiety. However, it was not always clear what actions were taken prior to medicines being administered. For example, there was no evidence that other avenues were explored such as diversion, moving to another area or assessing pain levels. Daily care records did not always provide a rationale to why PRN medicines had been given. For example, describing the person as 'settled all day' when medicine charts recorded that PRN medicines had been administered.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider had taken steps to ensure all wardrobes were secured to the wall. The provider had also arranged for all window restrictors to be replaced by an external contractor.

● Medicines were stored securely and safely.
● There were regular audits of medicines.
● Staff had training in medicines before they were able to administer medicines.

Systems and processes to safeguard people from the risk of abuse
● Staff told us they understood what to look for in relation to any potential abuse or safeguarding concerns. However, we found that staff were not always aware and attentive to people when they were showing signs of distress or need.
● There were systems to ensure any safeguarding concerns were actioned.
● The provider understood their responsibilities in reporting safeguarding concerns to the local authority and CQC.

Staffing and recruitment
● The provider's recruitment process included checks to ensure staff were of a suitable character. Staff files showed recruitment checks were robust, which included checks on staff through the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. Bins designated as taking clinical waste did not contain bags and soiled items were placed into these bins. Bathing items including showerheads and bath seats appeared unclean and people's rooms did not appear to be clean and hygienic.
● A room labelled as a storeroom was not secure and contained a hoist and a hoist sling which we were told by staff were used with people in the home. The room contained a toilet that we were told by staff was no longer in use. This toilet was soiled, and the room had a strong and offensive odour. We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We highlighted the concerns to the registered manager and when we returned for the second day of inspection the storeroom had been locked and was no longer in use. We also found action had started to be taken by the registered manager to prioritise areas that required cleaning. We have also signposted the provider to resources to develop their approach.

Visiting in care homes
● There were no restrictions to visiting at the time of the inspection.

Learning lessons when things go wrong
● The provider had systems to learn lessons when things went wrong, however these systems were not always effective in ensuring that actions were always identified in a timely way.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

- People did not always have the support to ensure that opportunities to maintain a healthy and balanced diet were maximised. For example, we observed 1 person sat in a chair through both days of the inspection. During both days there was toast and drink left on a table next to them, and we saw that staff did not actively encourage or attempt to support the person with the food and drink. This meant that food and drink went cold and was not consumed on both days of inspection.
- When reviewing the persons care records it identified that the registered manager and staff had concerns over the rate of weight loss and a referral had been made to the doctor for review. However, the last weight taken was in April 2023 which showed over a 4 kg weight loss since the last weight was taken in March. No weight had been taken in May even though this was when the referral had been made. There was no comprehensive recording of the persons food and fluid intake and with our observations of the times they were left with food and drink and no encouragement or support it was not possible to identify if the concerns were due to lack of support or the persons current health.
- Information in the kitchen, which the kitchen staff told us was a guide for preparing food and fluids to people's specific needs, did not reflect what was written in peoples care plans and risk assessments. The kitchen staff told us they were aware that the information was out of date and said "We know people's needs anyway." They told us they were told by staff if people's needs changed. During the inspection we identified where people's needs had changed and this had not been effectively recorded in the kitchen. This left people at risk of choking.
- Food ingredients were not stored in a way that ensured food would always be safe and fit for consumption.

The provider had failed to ensure that people's nutritional and hydration needs were met effectively. This was a breach of regulation 14(1) of the Health and Social Care Act 2008

- Immediately following the inspection, the registered manager organised a complete clean of the kitchen areas ensuring food was stored appropriately, also reviewing all documentation making sure it reflected people's current identified needs.

Staff support: induction, training, skills and experience

- Staff did not always have the skills, knowledge, training and experience necessary to provide effective care and treatment.
- The registered manager was unable to share a definitive matrix of staff training. We were provided with 2

different versions that provided conflicting information on what training staff had completed. Following the inspection, we were provided with another record of training which we were told by the registered manager was up to date. This showed that they had identified less than 7% of staff had completed any learning disability training, even though they were providing care to people with learning disabilities. Some staff we spoke with did not understand what was meant by the term learning disabilities. They were unable to explain what considerations were needed to ensure that people with learning disabilities had their needs met effectively

● There were 17 staff who had not had any training in the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS). This training is essential to ensure that staff have an understanding of capacity and consent.

The provider had not ensured that staff had the relevant qualifications, competence and skills necessary for their roles. This was a breach of regulation 19 (1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

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 MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Applications were made to the relevant authorities to deprive people of their liberty. However, we found the rationale behind those applications was not always clear. We questioned 1 application which had been made around the use of call bells. The staff we spoke to were unable to explain how and why the use of a call bell was being considered as a deprivation of liberty.

● We found the staff knowledge and understanding of the MCA and DoLS was not always consistent, and this also was reflected in how the registered manager and the provider were applying the principles of the MCA and DoLS.

Adapting service, design, decoration to meet people's needs

● The building layout provided people with access around their environment and provided space for the use of hoists and other specialist equipment. However, the environment was not well maintained and we saw there was broken furniture in communal areas. Also in some people's bedrooms we observed broken laminate on the flooring and loose light fittings.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's care records were not always person centred. Whilst assessments contained information about protected characteristics, for example gender and faith, care plans and risk assessments lacked information

about people's individual choices, likes or dislikes. There were no aims or aspirations about goals to achieve with individuals and this meant that people did not always experience care that was tailored to their individual needs.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People had access to health professionals when they needed. We found examples where people had been referred to the doctor due to concerns and where people had been referred to local mental health services and speech and language therapy services.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity, Respecting and promoting people's privacy, dignity and independence

● People were not always treated with dignity and respect. One person was screaming in their room. We saw that staff did not respond and when we spoke with the registered manager they told us that they would often scream with no obvious cause. However, when we went into this person's room we identified that they were in need of personal care. During both days of our inspection visits inspectors saw occasions when people appeared to be in distress with staff not appearing to respond. Due to our concerns the inspectors had to intervene and ask staff to respond. Another person during a walkaround with the registered manager was in a wheelchair with a runny nose. Even though staff were next to them and within the vicinity the registered manager had to intervene and ask staff to respond to the person's needs.
● One person when asked about staff told us, "Can't fault them, lovely carers, but it's not like home." We did see some positive interactions from staff and when they were providing care to an individual they treated them with respect, however on both days of inspection we observed that staff did not show awareness of the needs of people outside of the person they were focusing their attention on.

Supporting people to express their views and be involved in making decisions about their care
● One person told us their choices were respected and they had a choice over what they wanted to do. We saw that people had choices over what they wanted to drink or eat, however staff were not able to tell us about people's individual views. The registered manager was not able to demonstrate to us how people were involved in their care and care records also lacked detail about how people were involved in shaping their care.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences.

- There were comprehensive assessments of people's needs prior to moving into Waterside, however this information was not always transferred into the care plans for people. This meant a lack of personalised focus on the planned care and staff not understanding the individual characteristics of people in their care.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- There were opportunities for people to engage in group activities and the staff, employed specifically for activities, tried to engage people in these activities. However, some people were in rooms with their doors shut, unable to use call bells and only getting 'hourly checks.' This increased the risk of social isolation.
- Outside of planned group activities we did not observe structure to what people were doing through the day. There was no focus on encouraging people to develop relationships or to follow individual interests or hobbies.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Whilst images of food at mealtimes were used to assist people with choices, we did not see where there had been specifically adapted aids to assist with communication.
- Care records did not always contain information about how people specifically communicated. The lack of clarity for staff regarding people's communication needs was evident in the lack of response to apparent distress.

Improving care quality in response to complaints or concerns

- There was a complaints procedure, relatives told us they knew how to complain and we could see that the registered manager responded to complaints when they were made.

End of life care and support

- There was information in people's care records about end of life wishes.

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-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to 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-centred care.

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

- Although systems such as audits and checklists were in place and in operation at the service; they were not used effectively to keep residents safe.
- The provider's systems had failed to assess, monitor and mitigate risks relating to the health, safety and welfare of service users. Where risks were identified, measures to mitigate the risks had not been implemented.
- Checks and audits in place were ineffective. For example, maintenance checks undertaken on window restrictors had failed to identify some that were damaged and others that were not fitted in accordance with Health and Safety Executive (HSE) guidance. This was discussed with the Registered Manager and assurances were given they would address however, when we returned on the second day we found the actions taken by your maintenance team to rectify the issues found had failed to identify the continued damaged state of window restrictors.
- The building maintenance checklist had identified on 17 September 2022 that window handles needed replacing. When we visited on 11 May 2023, we found a window on the end of the first-floor corridor did not have a handle, meaning that it was not possible to close the window. The window also did not have an appropriate window restrictor. Action had not been taken to rectify the issue and this placed people at risk of significant harm.
- The building maintenance checklist had identified that wardrobes were not secured in people's rooms, leaving people at risk of significant injury. However, you only took action to secure the wardrobes after this was raised to you by inspectors.
- The kitchen audits did not identify what we found on inspection, which included unclean food preparation surfaces and the unsafe storage of food ingredients.
- There were no clear systems to ensure effective oversight of the training and competence of staff in meeting peoples individual needs.

The provider's systems and processes had failed to robustly assess, monitor and improve the quality and safety of the services and assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Our observations identified that for some people approaches were not tailored towards a person centred approach. There was not sufficient emphasis on individual characteristics in the care planning, and this led to staff not always being aware of what people's interests or preferred activities were. This meant that the full potential of achieving good outcomes for people was not always maximised.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics, 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

● There were systems in place to gather feedback from relatives, although the registered manager told us the uptake by relatives on giving feedback was low. The registered manager told us they had an open door to relatives to raise any concerns.

● We did not see any formal system of gaining feedback or measuring the outcomes for people that lived at Waterside.

● The registered manager understood their responsibilities under the duty of candour. Relatives we spoke with felt the registered manager responded to any concerns and they felt listened to.

Working in partnership with others

● The provider worked with a variety of health and social care agencies and statutory notifications had been sent to us for notifiable incidents.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to robustly assess the risks relating to the health safety and welfare of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure that people's nutritional and hydration needs were met effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured that staff had the relevant qualifications, competence and skills necessary for their roles.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider's systems and processes had failed to robustly assess, monitor and improve the quality and safety of the services and assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.

The enforcement action we took:

Warning notice