Runwood Homes Limited

Waterfield House

Inspection report

Grays Close
Hadleigh
Ipswich
Suffolk
IP7 6AG

Tel: 01473829103
Website: www.runwoodhomes.co.uk

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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
Waterfield House is a residential care home providing personal care to 54 older people, some living with dementia, at the time of the inspection. The service can support up to 76 people in one adapted building.

People's experience of using this service and what we found
There had been changes in the management of the service since our last inspection. We found a breach of regulation regarding governance. The key question Well-led was rated requires improvement at our last inspection. At this inspection, Well-led had not improved to good and Safe had deteriorated from good to requires improvement.

People were asked for their views about the service in meetings and surveys. However, where people had raised issues in the last five meetings about staffing levels and food, prompt action had not been taken to address their comments regarding staffing.

We found shortfalls in the staffing levels in the service. People were not always provided with the support they needed in a timely way. We found a breach of regulation regarding staffing. The provider updated us on the action they had taken and were taking to address this.

Improvements were needed in records, to show people received the care and support they needed, including if they had enough to drink each day and ensure staff received the guidance they needed to meet people's needs.

The current infection control systems in place reduced the risks to people. There had been no outbreak of COVID-19 in the service. Prior to our inspection, there had been a contagious outbreak, which was not COVID-19. During our inspection, we found improvements had been made to reduce future risks.

Staff were trained and understood their responsibilities in keeping people safe from harm and abuse. Risks to people were assessed and measures in place to reduce the risks.

The service had systems in place to learn from incidents and use them to drive improvement. A programme of audits were undertaken.

People received their medicines when they needed them. Medicines management was monitored and audited to ensure any shortfalls could be quickly identified and addressed.

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 16 November 2018).

Why we inspected
We received concerns in relation to staffing, care provided, record keeping, leadership and a contagious outbreak raising concerns about infection control processes. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only.

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 coronavirus and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at 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 read the report from our last comprehensive inspection, by selecting the 'all reports' link for Waterfield House on our website at www.cqc.org.uk.

Enforcement
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 as a result of 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. We have identified breached of regulation in relation to staffing and 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 for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Waterfield 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 Care Act 2014.

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 visit on 5 October 2020 was undertaken by two inspectors. The additional inspection activity, including reviewing records, speaking with staff and relatives and providing feedback, between the 5 October 2020 to 21 October 2020 was undertaken by one inspector.

Service and service type
Waterfield House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, at the time of our inspection, the registered manager no longer worked in the service. We had not yet received an application to cancel their registration.

Notice of inspection
We called the service to announce our inspection visit one hour before the inspectors arrived. This was to ask the service for specific information regarding COVID-19 and to ensure we were working within the provider's own COVID-19 and infection control procedures.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

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 all of this information to plan our inspection.

During the inspection
We visited the service on 5 October 2020. The remainder of the inspection were carried out remotely, away from the service.

We received feedback about the service from people who lived there, relatives and staff. We spoke with six people who used the service. We also received feedback from 18 people's relatives and 13 staff members, including the deputy manager, domestic staff, senior care staff and care staff. We also spoke with the regional operations director during our visit.

We reviewed a range of records. This included the full care plans for three people and sections of six people's care records. A variety of records relating to the management of the service, including audits and quality assurance were reviewed. We also reviewed records relating to medicine administration and monitoring, staff training and three staff recruitment files.

We fed back our findings from the inspection on 21 October 2020 to the group director of operations, the deputy manager and the new home manager who had started working in the service that day.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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.

Staffing and recruitment

- The minutes for the last five meetings attended by people using the service showed people were not satisfied with the staffing levels and response times of call bells, particularly at night. Prior to our inspection, we had received concerns about there not being enough staff to meet people's needs.
- Relatives told us about the impact staffing levels had on their family members. This included having to wait for staff support when they needed to use the toilet, and, "Accidents," had happened. One relative said, "It really upsets [family member], would be mortified if [they] wet the bed." We were told a person had started to use continence pads because they were so worried about having to wait for support from staff.
- Records of call bell response times showed people did have to wait for their requests for assistance to be provided. We reviewed records of call bell response times for some days over September and October 2020, responses varied from under a minute to 45 minutes.
- Staff told us how staffing levels impacted on people, including not being able to respond to requests for assistance quickly because they were assisting other people and they did not have time to spend with people. One staff member told us, "View of [management] was that we did not attend quickly enough, but you cannot leave someone when busy to attend a call bell."
- Some relatives told us their family members were bored. There were less activities and they were not receiving social interaction to bridge the gap of when they had regular visits from family prior to the COVID-19 pandemic. The activities staff were supporting relative visits during the pandemic. A staff member told us staff were allocated for activities but did not always happen because they were too busy.
- The service had a dependency tool to calculate the numbers of staff required. The tool used was not robust enough and did not consider, for example, the layout of the building. Records did not demonstrate the staffing rota had been adjusted to address people's changing needs, such as if a person required end of life care, or increased checks on their wellbeing.

Systems were not robust enough to demonstrate the staffing levels were sufficient to meet people's needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Prior to our inspection, the provider had introduced a twilight shift from 8pm to 12am to address people's concerns. The group director of operations said this shift would be changed to a whole night shift, as a result of our feedback. Following our feedback we were told night shifts would be extended, to support morning staff in the busy time of supporting people to get ready for their day. They were increasing domestic hours and staffing levels to support activities and relative visits.
- Staff recruitment was done safely, this included making appropriate checks to reduce the risks of people

being cared for and supported by staff who were not suitable for working in this type of service.

Assessing risk, safety monitoring and management
● There were systems to monitor people's weight loss. This included regular weight checks and referrals to health professionals. A staff member, who was a nutrition champion, was working with catering staff to improve the provision of high calorie snacks and food to support people to maintain a healthy weight.
● People's care records included risk assessments and guidance for staff on how risks were minimised. This included risks associated with falls and pressure ulcers.
● Systems were in place to monitor and reduce risks of falls. This included risk assessments and provision of equipment, such as mats which alerted staff when people attempted to mobilise independently.
● Regular checks were undertaken on equipment which reduced risks to people, including moving and handling equipment, and fire safety. Where shortfalls were identified these were reported and addressed.
● The contingency plan guided staff what they should do in an emergency. Personal emergency evacuation plans identified how people were to be supported if evacuation of the service was needed.

Preventing and controlling infection
● The provider was promoting safety through the layout and hygiene practices of the premises. Prior to our inspection, there had been a contagious outbreak affecting staff and people using the service, not COVID-19. At the time of our inspection improvements had been made. The provider was making sure infection outbreaks could be effectively prevented or managed.
● The service had scored 76% in the provider's infection control check in September 2020. Improvements had been made, including increased hand sanitiser dispensers. During our inspection visit we noted an odour on the first floor, records and discussions with staff demonstrated this was being addressed.
● We were assured that the provider was meeting shielding and social distancing rules and admitting people safely to the service. The provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was using PPE effectively and safely and accessing testing for people using the service and staff.
● We were assured that the provider's infection prevention and control policy was up to date.

Using medicines safely
● We observed part of the morning medicine administration. This was done in a caring manner and safely by the staff member responsible. People told us they got their medicines when they needed them.
● Records showed people received their medicines as prescribed. Audits and checks reduced risks associated with medicines management.
● Staff responsible for administering medicines had been trained and their competency was checked.

Systems and processes to safeguard people from the risk of abuse
● Discussions with staff demonstrated they had received training in how to recognise and report abuse.
● The service reported concerns to the relevant organisations, this included the local authority safeguarding team, who are responsible for investigating abuse, and to the Care Quality Commission (CQC).

Learning lessons when things go wrong
● The service had systems in place to learn lessons when incidents had happened. These lessons were provided to staff in meetings and reminders in notices which advised staff of their responsibilities.
● Where there had been shortfalls identified in staff practice, this had been addressed by the provision of training and/or disciplinary action.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There was inconsistent leadership in the service. The registered manager at our last inspection had left, since then there had been two other managers, the latter registering with the Care Quality Commission June 2020 and leaving in September 2020. A new manager started working in the service on the day of our inspection feedback.
- We received varying comments from relatives about if the service was well-led. One relative told us, "The past two managers have not been very good at managing, it has gone downhill." Another said the standards were, "Slipping," in the service. The provider was addressing concerns about leadership in the service, however there had not been stable and consistent management to drive continuous improvement.
- At our last inspection, the key question Well led was rated requires improvement due to shortfalls in the service's recording systems. During this inspection, enough improvement had not been made in Well-led and Safe had deteriorated to requires improvement, with a breach of regulation relating to staffing.
- Prior to our inspection, we received a concern which identified issues with records, for example people's oral care and fluid intake. Some improvement had been actioned by the increased monitoring of records, but enough improvement had not been made.
- The system was not robust for monitoring people's fluid intake. Although records of what people had to drink daily were completed and checked, there were no recommended targets for how much people should have to drink and when referrals should be made to health professionals. Records showed the GP had been advised of people's low fluid intake, but the system was not robust enough to ensure it was consistent.
- Care records included information about people's needs and guidance for staff about how these needs were to be met. There were positive areas in care plans which demonstrated staff knew people well. However, some improvements were needed, for example one person's records did not explain their behaviours associated with their condition and how these affected the person. Another person's care records stated they required support with denture care, but also said they did not wear their dentures. Therefore, we could not be assured staff had the guidance needed to effectively meet people's needs.
- People were asked about their views of the service in surveys and meetings. In the last five meetings people raised concerns about the quality of food and staffing levels. Some action had been taken in response to comments regarding the food provision. However, shortfalls in staffing levels showed people's comments and concerns had not been addressed to improve their experiences.
- Staff feedback varied about how the service was led. Some staff told us they felt listened to, others told us

they felt they were not, and no changes were made when they raised concerns, such as staffing levels. Staff told us they did not have the opportunity to discuss their concerns and suggestions in meetings. One staff member said they felt they were, "Talked at." Some staff told us morale had been low. One staff member said they had been reprimanded in front of colleagues which they found humiliating.

There was an inconsistent leadership in the service and governance systems were not robust. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We received positive comments about the deputy manager from staff and relatives.
● There had been some areas of improvement, including the introduction of staff champions who took responsibility in areas such as nutrition, fluids, dignity, moving and handling and oral care. This was not yet fully implemented and embedded in practice.
● Despite concerns staff had about staffing levels and leadership, they were committed to providing good quality care and they spoke about people in a compassionate way. People and relatives told us the staff were kind. Observations during our visit demonstrated staff were caring in their interactions with people.
● People's relatives told us they felt they were mostly kept updated and consulted about their family member's wellbeing. Prior to our inspection, weekly feedback telephone calls to relatives were introduced to update them on their family member's wellbeing. Relatives told us they were happy with this system. Some relatives told us about newsletters which provided updates on the service.
● Prior to the COVID-19 pandemic relatives' meetings were held. Relatives said these were well attended. Two relatives told us there had been two virtual meetings during the pandemic, which had not been well attended and were stopped. These were reintroduced 14 October 2020 to ensure relatives had a forum to discuss what was happening in the service.
● One relative told us how staff had put up signs in their family member's bedroom because they could not find their way around, which they saw as positive. Another relative told us how a staff member helped them to put up relative's photographs in their bedroom, so they could see them, even when they could not visit.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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 was a winter plan in place. This included information of how the pandemic was being managed.
● Staff told us they had the training they needed. Records showed staff had been trained in subjects including COVID-19, oral care, pressure ulcers, dementia, fluid and nutrition, moving and handling, equality and diversity and Mental Capacity Act and deprivation of liberty safeguards.
● A programme of audits were undertaken and action plan for improvement was in place.
● The provider's monthly governance bulletin from August 2020 posted in the staff room, included learning from infection control audits and gave staff guidance, including wearing of personal protective equipment. The staff room also included guidance for staff, such as whistleblowing and the code of conduct.
● We continued to receive information from the service regarding specific incidents, as required.
● The service had a duty of candour policy in place and records reviewed showed an apology was provided in response to complaints and incidents.

Working in partnership with others
● The service worked with other professionals involved in people's care. This included commissioners, GPs, occupational therapists and dieticians.

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 17 HSCA RA Regulations 2014 Good governance There was an inconsistent leadership in the service and governance systems were not robust. Regulation 17 (1) (2) (a) (c) (e) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Systems were not robust enough to demonstrate the staffing levels were sufficient to meet people's needs. This placed people at risk of harm. Regulation 18 (1)