Carebase (Hemel) Limited

Water Mill House Care Home

Inspection report

Rose Lane (off Red Lion Lane)
Hemel Hempstead
Hertfordshire
HP3 9TE

Tel: 01442269888
Website: www.watermillhousecarehome.co.uk/

Date of inspection visit:
04 July 2023
19 July 2023

Date of publication:
20 September 2023

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
Water Mill House is a residential care home registered to provide personal and nursing care to up to 70 people. The service provides support to older and younger adults, people with physical disabilities or sensory needs and people living with dementia. At the time of our inspection there were 64 people using the service.

The service is a modern purpose-built premises organised across three floors. Each floor has ensuite bedroom facilities (mostly single occupancy, but there are some double rooms for couples or people who wish to live together) and large communal spaces. There is a bistro on the ground floor, along with a hair and beauty salon, and large, well-maintained gardens.

People's experience of using this service and what we found
Care plans and risk assessments were not always accurate, and information was not consistent to ensure staff had the right guidance to provide safe care to people. Daily care records were completed erratically and therefore did not provide a true picture of the care people were offered and received. This put people at risk of harm because it was not possible to monitor effectively to ensure planned care was still appropriate to people's needs. Where 1 person had been assessed to have lost significant weight, there was no evidence of any action taken to reduce the risk to their health and wellbeing. This put them at risk of harm.

Medicines were not always managed safely. Information about people's allergies was not recorded on medicines administration records, including allergies to certain medicines. The registered manager took immediate action to address this during the inspection. The provider had not ensured medical devices were maintained appropriately which may affect how they work.

The provider had systems in place to monitor the quality of the service, but these were not used effectively to identify shortfalls and make improvements.

People and their relatives told us they felt safe, and staff cared for them well. There were enough staff to care for people safely and, although busy, we saw they had time to speak with people as well as carrying out their other duties. The service was clean and well maintained.

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.

The provider and the registered manager demonstrated a strong commitment to providing good quality, person-centred care. They were quick to respond to feedback and there was evidence that information was shared with staff when things went wrong to support learning and make improvements. They were clear about their expectations of staff to work in line with the provider's values, and worked hard to develop the

team, providing support to staff who wanted to progress in their career.

People, their relatives and staff spoke positively about their experiences of the service. There was a pleasant atmosphere in the service and people, relatives, staff and management appeared to enjoy positive relationships for the most part.

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 (published16 September 2021) and there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to infection prevention and control. At this inspection, although enough improvements had been made in relation to infection prevention and control, we found new areas of concern and the provider remained in breach of Regulations. The rating remains requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
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 inspection was prompted in part due to concerns received about infection control, the approach taken by the management team, the culture in the service and the quality of care at night-time. A decision was made for us to undertake a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We found no evidence during this inspection that people were at risk of harm from these concerns. However, we have found evidence that the provider needs to make improvements to some other areas. 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 Water Mill House on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to the management of risk to people's health and wellbeing and in how systems are used to monitor the quality of the service and drive improvement.

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 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.

Water Mill House Care Home

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
This inspection was carried out by 3 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
Water Mill 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. Water Mill House 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. Inspection activity started on 04 July 2023 and ended on 19 July 2023. We visited the service on 04 and 12 July 2023.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We reviewed feedback provided to us by the local authority. 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
Through a combination of in person conversations and telephone interviews we spoke with seven people and 13 relatives. We also spoke with 14 staff including 7 care staff, a nurse, a housekeeper, a general assistant, 2 assistant managers, the registered manager and the provider's business manager. We looked at the care records for 6 people and the medicines records for a further 14 people living at the service. We looked at a range of records relating to the management of the service including quality monitoring and auditing records, recruitment and staff deployment documentation and policy documents relating to areas such as infection control, medicines management and safeguarding people from harm.

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.

At our last inspection, we found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because measures to protect people from the risk of infection were not sufficient. At this inspection, although we found improvements had been made in relation to infection prevention and control, we identified new areas of concern and the provider remained in breach of Regulation 12.

Assessing risk, safety monitoring and management

● The provider used an electronic care documentation system which produced generic information about specific medical conditions within the relevant section of the care plan. Although this information was very detailed, it had not always been edited to ensure the information related to that person's specific needs, and how the medical condition affected them. This put the person at risk of harm because staff could not be sure the information was relevant to the individual rather than just general information about the condition.

● Information in care plans and risk assessments was not always consistent to support staff to know how to care for people safely. Some records were not fully updated to reflect changes in people's needs. For example, records for 1 person indicated their skin was intact but elsewhere that they had pressure damage. They were described as independently mobile and at low risk of falls, but elsewhere as requiring support to mobilise and as being at high risk of falls. This put the person at risk of receiving unsafe or inappropriate care.

● Some information used to calculate risks was not accurate - such as ascribing the incorrect sex or age when assessing skin integrity or nutritional risk. This is important because personal characteristics, such as age or gender, can influence the scoring and therefore change the outcome of the assessment and lead to inappropriate actions being taken.

● In June 2023, 1 person was assessed to have lost over 9% of their body weight over the previous 6 months which raised their Malnutrition Universal Screening Tool (MUST) risk level to 2, which means high. In July, despite them losing further weight, they were calculated to have lost just 2% of their body weight in the previous 6 months bringing their MUST score down to 1. These scores could not both have been correct but there was no indication on the record that the first calculation was wrong. When a person's MUST score is high, we would expect to see evidence of action taken to reduce the risk. This might include making adjustments to the person's diet, increased monitoring or a referral to a dietitian. There was no evidence on the record to indicate that any action had been taken or referrals made. This put the person at risk of harm because their weight loss was not being accurately monitored and support was not in place to reduce the risk to their health and wellbeing.

● Daily care records were not always recorded accurately and there were frequent gaps in entries, for

example, in fluid intake records. Where people required regular repositioning to reduce the risk of pressure damage, records suggested this did not happen as frequently as people's care plans required. An assistant manager told us staff were not always completing records at the time care was delivered, which resulted in the records being an inaccurate reflection of the care provided. This puts people at risk of receiving inappropriate or unsafe care because it was not possible to be sure people had received care as per their assessed need.

● The daily records also suggested people's care plans were not always followed. For example, 1 person's care plan required them to be offered additional snacks at night, but there was no record of this happening. This person also required staff to support them to mobilise regularly to reduce risk of pressure damage but again, the daily logs had no record to indicate this happened.

● Although the provider had a service improvement plan in place that identified the need for improved accuracy in care documentation, progress towards achieving this was slow and had not yet resulted in sufficient improvements. This put people at risk of receiving unsafe or inappropriate care.

Systems to assess, monitor and reduce risk to people's health and wellbeing were not used effectively. This put people at risk of harm. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the Registered Manager shared with us the actions they were taking to make improvements in addition to those already seen on the service improvement plan. This included making improvements to the auditing of care documentation to ensure issues were identified and addressed in a timely way, additional equipment to ensure staff had access to handsets to record care as and when it took place, and additional training for staff in relation to care planning and risk assessment.

● The management team ensured the service and the equipment used by people and the staff team were checked and serviced regularly. This included fire safety equipment. People had plans in place for evacuating the service if there was an emergency.

Using medicines safely

● Medicines care plans were in place to help staff support people with their health needs. However, 1 person's care plan for a specific condition did not have guidance about when to contact the emergency services. The person had not experienced symptoms of their condition for many years. However, they were still prescribed medicines for the condition and could experience symptoms requiring medical attention at any time. Therefore, this put this person at risk of harm.

● The provider did not ensure medical devices were appropriately maintained. We found a syringe driver which had not been calibrated as per the manufacturer's instructions. This meant the equipment may not work as intended. A syringe driver is a small portable battery-operated pump that administers medicines by continuous infusion. Blood glucose monitors had not been quality checked. This meant the blood glucose monitors may not have provided accurate readings.

● Medicine Administration Records (MAR) did not all contain information about people's allergies. Some people had medicine allergies and were therefore put at risk of harm.

Medicines were not managed safely. This placed people at risk of harm and was a further breach of Regulation 12 of he Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager took immediate action to ensure allergy information was recorded on the MAR for all people using the service.

● We observed staff giving medicines to people. The staff were polite, gained consent, and signed for each medicine after giving it on the MAR.

● Medicines including controlled drugs were stored securely and at appropriate temperatures.
● The local GP or the clinical pharmacist from the GP practice had carried out regular medicines reviews for people living at the service.
● People and their relatives mostly told us they were happy with the support they received in relation to their medicines. One relative said, "(Family member) takes a lot and it's given by the person in charge of medicines. They are spot on with their timing."

Preventing and controlling infection
● Before the inspection, concerns were shared with us about the cleanliness of the service and staff practice in relation to infection control. We found no evidence to support these concerns. The service was clean and well maintained throughout. For the most part, people and their relatives told us this was generally the case. Comments included, "The home is clean and they clean (family member's) room. It's more like a hotel than a care home." and "I feel it is clean and fresh."
● 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.

Visiting in care homes
● The provider's approach to visiting was in line with current guidance about visiting in care homes. The service was fully open to visitors. We saw many people were receiving visits from family and friends during the period of inspection.

Staffing and recruitment
● Before the inspection, concerns were shared with us about the standard of care and attitude of staff at night. Some people and relatives we spoke with also felt there was a difference in how they were supported at night. Comments included, "Sometimes the night (staff) aren't as proactive as the day. " And, " (Family member) says that the (staff) in the day are better than at night." However, another relative said, "(Family member) is safe at night 100%."
● We discussed these concerns with the registered manager, who was already aware that there had been some issues at night time. They provided evidence of actions they had taken to address this. This included increased night shift monitoring, formal supervision, guidance and mentoring for night staff to develop their skills. The registered manager had also recently completed a week of night shifts to identify issues at night and how to support improvements. We were confident the registered manager was taking appropriate action to address these issues.
● The provider mostly completed recruitment checks in line with legal requirements to help ensure staff were suitable for their job roles. However, we found in 2 out of 3 staff records we reviewed, there were gaps in information about their employment history. Following the inspection, the provider gave us assurance that action to address this was in progress.
● For the most part, people and their relatives told us there were enough staff to safely support them. Staff also confirmed this. During the inspection, people did not have to wait a long time to be supported and staff,

although busy, had time to talk to people as well as complete their other duties.
● There was a consistent staff team at the service. The provider had worked hard to recruit to vacancies at the service and had not required the use of agency staff for 12 months. This meant people were supported by staff they were familiar with and who knew them well.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe. One person said, "I feel very safe here. If I did not feel safe here, I would talk to a member of staff." Relatives also felt their family members were safe. Comments included, "(Family member) is safe, staff are very attentive. Staff care to (their) needs." And, "Absolutely (family member) is safe. (They) were not safe living at home. The staff are there and they look after (them)."
● Staff received training in safeguarding and had good understanding of what abuse may look like. They were confident to report any concerns both to managers of the service and externally to the local authority or CQC.
● The management team reported safeguarding concerns appropriately to the relevant authorities.

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, or in progress, to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.'

Learning lessons when things go wrong
● The provider and management team reviewed accidents and incidents and took action if this was necessary.
● Actions and findings were shared with the staff team in meetings and at handovers to promote lessons being learned.

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 requires improvement. At this inspection the rating 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-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had systems in place to monitor the quality of the service, but these were not always used effectively to drive and sustain improvements. Although some issues identified at this inspection had been picked up by quality audits, others were missed, and some action taken was not yet effective and required strengthening.
- Through audits, the management team identified that daily records were not always completed accurately or at the time care was delivered. However, insufficient action was taken to monitor for improvements and address continued shortfalls. This meant that daily care records did not provide the management team with a reliable picture of the care offered and provided to people. Therefore, the management team could not use these along with their first hand observations and handovers to judge accurately whether planned care was meeting people's needs or whether changes were required.
- The care plan audit system identified some concerns with the timeliness of care plans being developed for people newly admitted to the home, but had not identified the inconsistency of information we found during our review of these documents. Staff completing audits did not have strong understanding of how to use audits to drive improvement.
- The registered manager had a service improvement plan which identified target dates for actions to be completed and who was responsible for ensuring the work was done. However, due to audits not identifying significant areas for improvement, this was not as effective as it might have been.

Systems to monitor quality were not used effectively to make improvements to the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the registered manager shared with us their plans to improve quality monitoring systems and record keeping within the service. This included updating audit tools to cover areas that were previously not considered, targeted supervision and training for staff in relation to auditing, care planning, risk assessment and record keeping. They also planned to purchase additional equipment to ensure staff always had access to the electronic care documentation system.
- The registered manager demonstrated good understanding of their role and recognised the need for strong leadership and clear direction throughout the service. They also recognised the need to prioritise the development of staff in senior positions to achieve this. They understood their legal responsibility to notify

CQC and the local authority of reportable events and submitted these notifications appropriately.

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

● Before this inspection, concerns were shared with us about the management team's approach, the culture in the service and the quality of care at night. Overall, through our observations and discussions with staff, management, people and their relatives, we found no evidence to indicate people were at risk of harm from the concerns raised in relation to the management approach and the culture of the service.
● The registered manager had taken decisive and appropriate action to explore concerns in relation to night-time care. This included increased formal supervision and developing the relationship between day and night staff. The registered manager also undertook a week of night shifts which helped them to identify staff development and support needs.
● Staff we spoke with had good understanding of what person-centred care looked like, and showed a commitment to the service, their team members and the people they supported. Staff, people, and their relatives told us there was a positive atmosphere in the home and most said that staff morale was good. During the inspection, there was a warm, friendly atmosphere in the home. Staff, people and managers appeared to have positive relationships.
● The registered manager and the provider had a strong commitment to person -centred care and were working hard to support the development of the staff team. They did this in a number of ways including training, setting out clear expectations in relation to the standard of care expected through team meetings, group and individual supervision meetings, and team building trips away with groups of staff.
● The provider sought feedback from people, their relatives and staff about the quality of the service. They did this through a recent quality survey, individual meetings with people, opportunities to share suggestions for improvements, and routine communications with people and their families. There were regular resident's and relative's meetings, some of which were face to face, and others through video link.
● In the main, people and their relatives told us that the manager was approachable, and they could speak with them or staff if they had any concerns. Comments included, "I know the manager and (they) are a lovely (person). We see (them) around the home." And, "I find the manager very friendly, approachable and competent." However, some felt that communication was not as good as they would like and made comments such as, "The communication needs to improve."
● Staff mostly spoke positively about the registered manager and the management team. They told us the management team were open and approachable. Most had confidence that any issues they raised would be listened to and appropriate action taken. They told us they felt encouraged to make suggestions and be part of making improvements to the service.

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; Continuous learning and improving care
● The provider understood their legal responsibility to be open and honest when things went wrong. Relatives confirmed the staff and management informed them appropriately of any incidents within the service.
● The provider and the registered manager were committed to supporting the development of staff and found 'acting up' opportunities for staff wanting to progress in their careers.
● There was evidence that, when incidents or accidents occurred, staff were supported to learn from these and make improvements.
● Relatives told us they had been given the opportunity to join training events to support them to understand their family member's condition. 1 relative said, "I attended a virtual dementia course recently. It

was for staff, but they made it available to relatives. It was brilliant."
● The registered manager and the management team demonstrated a positive and responsive approach to feedback throughout the inspection process.

Working in partnership with others
● Overall, the service worked in partnership with others to support good outcomes for people. For example, people had good access to their doctor and the pharmacist supported the home well with medicines reviews. The service also worked closely with the local hospice to support good end of life care for people.
● The service worked well with the local community to support people to have a better quality of life. For example, on the day of the inspection, a group of children from a local school visited the service to spend time with people.

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 17 Registration Regulations 2009 Notification of death or unauthorised absence of a person who is detained or liable to be detained under the MHA Systems to monitor the quality of the service were not used effectively to identify shortfalls in quality and take action to make improvements.

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 People were not protected from unsafe care because risks to their health and well being and medicines were not managed effectively.