Winsor Care Services Limited

Winsor Care Services

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Winsor Care Services is a domiciliary care service providing personal care to people living in their own homes. The registered manager told us there were 68 people using the service but they were unable to give us the exact number of people receiving the regulated activity of personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. We only reviewed the records of people confirmed to be receiving personal care.

People's experience of using this service and what we found
We found evidence of repeated breaches of regulations identified at the last inspection and that not enough improvement had been made.

There was lack of management oversight and a lack of reliable systems to inform the management of the quality of care people were receiving. People's records showed medicine errors and incidents of people missing their medicines occurred. There was evidence people experienced missed, late or much shorter than required care visits. Staff were deployed unsafely and told us, they felt rushed to provide the care people needed.

The provider did not always inform the local authority of safeguarding concerns and did not communicate effectively with health and local authority professionals regarding investigations. The registered manager did not uphold their regulatory responsibility of notifying the CQC of all notifiable incidents when required to do so.
The provider failed to ensure people had risk assessments in place for known risks relating to their conditions and incidents to people occurred as a result of poor risk management. People's care records did not reflect people's current needs, choices or preferences.

People and their relatives told us, they experienced the continuity in the staff supporting them. Staff told us, they got to know the people they supported and their preferences. The continuity in rotas meant that the familiarity of staff with people reduced the impact of poor-quality assessments and care plans. People were supported to have choice and control of their lives and staff supported them in the least restrictive way and in their best interests; the policies and systems in the service supported this practice.

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 21 October 2022) and there were 6 breaches of regulations found. 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 the provider remained in breach of regulations.

At our last inspection we recommended that people were involved in the care planning and given a choice of who they wanted to support them and that feedback from people was more consistently collected. At this inspection we found that people were not always involved in their care planning and feedback was not consistently sought from people, despite some improvements.

Why we inspected
The inspection was prompted in part due to concerns about risk management leading to incidents and accidents which had not always been reported to the CQC or local authority. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, responsive 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.

Enforcement and Recommendations
We have identified breaches in relation to, person centred care, safe care and treatment, safeguarding people from the risk of abuse, duty of candour and good governance. Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Winsor Care Services

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.

Inspection team
The inspection was carried out by 2 inspectors.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

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
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 25 May 2023 and ended on 20 June 2023. We visited the location's office on 25 May 2023.

What we did before 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. The provider did not complete the

required Provider Information Return (PIR). This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make. Please see the well-led section of this report for further details. We also reviewed intelligence information we held on our system including notifications about important incidents. We used all this information to plan our inspection.

During the inspection
We spoke with 4 people who used the service and 4 relatives. We received feedback from 6 professionals involved in people's care. We spoke with 6 staff members including the registered manager. We looked at 5 people's care records, their daily notes, medication and care visit records. We looked at 4 staff recruitment records.

Inadequate

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. The rating for this key question has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection we found the provider had failed to ensure risk assessments accurately reflected people's care and support needs. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found not enough improvement had been made and the provider was still in breach of regulation 12.

- The provider failed to assess risks and ensure staff were provided with clear guidance on how to mitigate risks. There were no risk assessments for catheter care, diabetes and skin deterioration where these were known risks to people.
- Risk assessments which had been completed did not always accurately determine levels of risk and people's records gave contradicting information. For example, one person's care plan stated they were at high risk of pressure damage and their risk assessment stated the risk was low. External health professionals had reported concerns that a person had developed a pressure sore and was not being supported appropriately.
- People's records lacked detailed moving and handling direction for staff to follow. One person's record directed staff to 'take safety measures' without explaining what these were. Another person's record did not detail the equipment to be used when supporting a person to reposition. There was evidence of people experiencing incidents as a result of the lack of clear guidance how to assist people safely. Some staff told us they sought guidance of how to support people directly from them rather than records.

The provider had repeatedly failed to establish systems to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider had not ensured safe management of medicines which resulted in people being at risk of harm. This was a breach of Regulation 12 (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 12.

● People's medicine administering records (MAR) failed to demonstrate people had received their medicines in line with their prescriptions. We saw repeated errors, such as gaps in records which could not be accounted for. This meant there was no reliable way of evidencing people had been supported with their medicines safely and as prescribed.
● People that have been prescribed time specific medicine were at risk of not receiving these as prescribed as the staff were unable to access the MAR from the earlier visit. One staff member told us, "You wouldn't see it because its individual forms. Only the blister pack if one hasn't been popped you would query it." This meant people were at risk of harm resulting from time specific medicine not being administered as prescribed.
● It was not always clear what level of support people required with their medicines. There was conflicting information in people's care plans and it was not always clear if people's medicines were to be administrated by staff or family members. This meant there was a risk people would not receive their medicines as required.
● There was no evidence of that the provider monitored the safe recording of medicines. Audits of medicine records had duplicated information and the information recorded for people was not relevant to their prescriptions. This meant people were at risk of being supported unsafely with their medicines.
● The provider had not assessed staff competency in supporting with medicines. Records of infrequent spot checks of staff did not detail observations of medicine administration.

The provider had repeatedly failed to ensure safe management of medicines which resulted people being at risk of harm. This was a continued breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had received training in medicines. We saw that staff training involved the use of medicine dispensary boxes to demonstrate safe administration of medicines.
● People told us, they felt staff supported them well with their medicines. One person told us, "My medicine is taken care of. I have nothing to worry about."

Learning lessons when things go wrong

At our last inspection systems and processes in place were not effectively managed to drive improvements to the quality and safety of the services provided. This was a breach of regulation 17 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.

● There was no evidence the provider had a system that would enable them to learn lessons from incidents and accidents.
● A summary of incidents and accidents shared with us by the registered manager showed none occurred within a 3 month period. This contradicted the incident and accident notes we found had been recorded by staff. This meant the manager lacked oversight of incidents which had taken place. Additionally, a summary of incidents and accidents had been completed for future months when that data was yet unknown. This meant there was no reliable system for the provider to record, monitor and analyse any trends.
● Actions following incidents and accidents were not consistently recorded by the provider. There was not always a record of an investigation or evidence relating to an incident. This meant the provider missed the opportunities to identify areas for improvement or to learn lessons.

The provider had repeatedly failed to have systems and processes in place to drive improvements to the quality and safety of the services provided. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to ensure safe staffing levels. This was a breach of regulation 12 (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 12.

● The provider failed to ensure people were supported by staff arriving to care visits on time and were staying the full length of the visit. The systems used by the provider for scheduling visits showed multiple alerts relating to late and missed care visits. The registered manager told us due to technical difficulties with the system people's visits were recorded manually by the office team. This meant there was no evidence people had their support as planned
● Staff rotas showed some care visits had been scheduled for the same time. Additionally, the travel time required between care visits had not been accounted for. Staff told us they could not always reach people on time and felt rushed. One staff member told us, "You get late, clients are calling you. Some of us have the client's numbers but if not, you call the office. At times in the office, they are also muddled about the message, and it doesn't get to the client quicker than us calling ourselves." Another staff member told us, "I think with the time in the morning it is always busy, we have to rush from one clients house to another." This meant due to poor deployment and planning there was a risk people would not receive care safely and as planned.
● Staff used electronic system to log in and out of care visits and there were frequent occurrences on the system of staff being present for a much shorter time than required. For example, according to the monitoring system, one staff member stayed for less than half of the allotted time for 13 out of 19 care visits in one day. This meant people were at risk of not receiving care safely and for the required amount of the time assessed.
● People and their relatives told us care visit timings could vary. One relative told us, "Not so keen on the surprise times, when they come much earlier. Instead of 8:45, it was 7:45." We saw records that one relative had made the provider aware that care visit timings were 'erratic'. No changes had been made as a result of this feedback.

The provider had repeatedly failed to ensure safe staffing. This was a continued breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had repeatedly failed to ensure they carried out the necessary pre-employment checks to check staff's suitability for the role. This was a breach of regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

● Staff were recruited with appropriate checks in place. We saw that staff records had been updated and references sought retrospectively in response to our last inspection.
● Staff recruited since the last inspection had all pre-employment checks in place. Staff had been confirmed

as having the right to work in the UK, had photo identification in place and relevant employment history.

Systems and processes to safeguard people from the risk of abuse
● The provider did not meet their safeguarding responsibilities to inform the local authority of concerns relating to a potential abuse, and the feedback we received showed the provider did not always cooperate with the timely sharing of information.
● We saw records of care notes referring to peoples injuries which had not been referred to the local authority for consideration against Section 42 of the Care Act to safeguard them.
● The local authority reported the provider was not forthcoming with information to manage risks. One professional told us, "I had to ask them multiple times to send me the answers to my questions relating to the safeguarding, however, answers were not linked to the safeguarding. It was really hard to get the right answers to my questions."

The provider had failed to safeguard people from actual or potential abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were aware of their responsibility to ensure people were protected against the risk of abuse and had an understanding of safeguarding. One staff member told us, "It all includes abuse, like neglect, financial. For example, family can neglect if they have provided no food, and I document it and report it."
● People and relatives told us they felt safe in the care of the staff. One relative told us, "My husband has great confidence in (carer); he feels safe with him."
● Staff told us they were familiar with the provider's safeguarding policy. They told us, "I make sure clients are alright mentally, physically, they are well taken care of and are stable. I would call the office if I was suspicious of things."

Preventing and controlling infection
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was promoting safety through the hygiene practices they applied when supporting people in their homes.
● We were assured that the provider's infection prevention and control policy was up to date.

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 requires improvement. The rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

At our last inspection, the provider had failed to ensure people received person centred care. This was a breach of regulation 9 (Person-centred care) 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 9.

● The provider did not always assess people's needs and choices prior to the commencement of the support being provided. Assessments carried out by third parties were used to inform people's care plans. People's individual choices and needs were therefore not always recorded. This meant the information could be inaccurate or outdated and therefore people could receive ineffective support.
● The above was confirmed by feedback from people's relatives. One relative told us, "Not that I can remember" One person told us, "I have a universal care plan…. we gave that to Winsor Care when I started using them." Another relative told us, "The hospital must have given Winsor care some information about who they are going to see and what [person's] condition was."
● The provider and registered manager were not using any recognised good practice and national tools to ensure that people's care needs had been assessed and would be provided appropriately. For example, reference to NICE guidance to assist them in relation to moving and handling and skin integrity.

The provider had repeatedly failed to ensure they provided people with person-centred care. This was a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Referrals were not always made without delay to make sure that people's health and wellbeing was maintained or improved. There were multiple concerns about people's skin deterioration raised by health professionals which the local authority had contacted the provider about. There were care records to show skin deterioration had been identified by staff but had not been referred for support in a timely manner by the provider. This meant people were at risk of unnecessary deterioration of their condition by neglect.
● Directions provided by health professional for supporting people with healthcare needs were not always

referred to in people's care plans. For example, one person required staff to use sliding sheets to support them to reposition, but this was not detailed within the daily support needs. This meant staff who were unfamiliar with people's needs would not know which equipment to use and how to use it safely

The provider had failed to consistently mitigate risks to people's safety. This was a breach of regulation 12 (Safe care and treatment) 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. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA

● The provider relied upon the local authority to assess people's capacity to consent to care. People and their relatives told us staff obtained people's consent to treatment and care.
● Staff had a good understanding of seeking consent from people before they provided care. One staff member told us, "We make sure we ask the person if they want us to do something before we do it."
● Where people's consent forms had been signed by people's relatives it was not always clear that was lawful

We recommend the provider ensure they have systems in line with the code of practice.

Staff support: induction, training, skills and experience

At the previous inspection the provider had failed to ensure that staff received appropriate support, training and supervision as was necessary to carry out the duties they were employed to perform. This demonstrated a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer breach of regulation 18.

● The provider had made improvements and the training matrix showed core training programmes had been completed for all staff.
● Staff told us about examples where they had been provided with specific training according to people's needs. One staff member said, "We had a client who was feeding through the PEG (Percutaneous Endoscopic Gastrostomy). We had a nurse who came and trained us about the PEG." A PEG is a flexible feeding tube which allows nutrition, fluids and/or medications to be put directly into the stomach.
● Staff told us they felt they had the training necessary to do their job. One staff member told us, "They provide us with advice and training we need."

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

- Staff supported people to eat and maintain good hydration.
- People felt supported to eat and drink sufficiently. One person told us, "I would not have [ready meals]. They cook what I ask for. And they buy stuff and surprise me, things I have never had before, and it tastes nice. I look forward to my meals." Another person told us. "I lost 4 stone while I was in hospital. I have put on a bit of weight since because they make sure I eat proper meals; they encourage me to eat."

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 requires improvement. At this inspection the rating has remained 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

- People told us staff treated them well and said that staff 'fitted into' their lives. One person told us, "Every afternoon we go somewhere, just for a walk, and they come with us. They are included in our family things if they want to be. They come to the consultant with me. They are part of everything. We have developed a good relationship and it has to be that way."
- Staff were respectful of people's differences. One person told us, "I have a diverse identity. I don't always go by male pronouns. I needed someone who was going to be accepting of that. The person I have been working with has been great; really kind, really friendly. There has never been any judgement."
- Staff spoke about supporting people in a way that considered their varied needs. One staff member told us, "They are all different characters. Some prefer a social call. They ask can we have a chat and a cup of tea or a meal with me and I enjoy it."
- Although people's feedback reflected staff treated them with kindness and consideration, the provider's systems and process did not demonstrate a caring and respectful approach to people's support. This included areas such as failing to monitor the timings of people's care calls and poor staff deployment that resulted in the support being delivered in a rushed way

Supporting people to express their views and be involved in making decisions about their care

We made a recommendation to the provider at the last inspection to review their systems in place to ensure peoples preferences and choices were adhered to. They had made some improvements to the delivery of care.

- The provider had made improvements to ensure peoples choices were considered by staff. Relatives told us that staff consulted them when people could not make their choices known. One relative told us that all staff who visited knew how to provide care in the way her husband needed and, "If they don't know something, they ask". Another relative told us, "It is very much working together as a partnership."
- Staff told us they gave people choice on a day-to-day basis. One staff member told us, "You give them choice, see how they want things doing."
- People were given choice in relation to the staff who provide their personal care and support. One person told us, "I asked for the person who was coming to be changed. And they did that really quickly, which was good."

Respecting and promoting people's privacy, dignity and independence

● People and their relatives told us they were treated with respect. When asked if they felt staff were respectful, one relative said, "Very much so."

● People were encouraged to maintain their independence. One staff member told us, "For instance if you are washing someone, give them the flannel, give them a chance to do it themselves."

● Staff respected people's privacy. One person said of a live-in carer, "They give us our privacy, they always knock before they come into a room."

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 requires improvement. The rating for this key question has remained 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; 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.

At the last inspection we found the provider had failed to ensure people received person centred care. This was a breach of regulation 9 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 9.

- People's care plans were not always person centred and lacked information about people's backgrounds, life histories, individual preferences, interests and aspirations. This meant staff did not know people well, and people could not receive support to meet their needs and choices.
- The provider did not always support people to ensure their individual communication needs had been met and did not always provided information in a way that was assessable to people. This meant that people were not always included in their care and had equal access to the service. The registered manager told us that one person preferred if they were spoken to in their first language which was not English. However, there was no evidence of any attempts to provide information or care in that person's first language.
- Although care plans included a section detailing people's communication needs, it was not always clear as to the most effective way to communicate with them. For example, within one person's care plan there was reference to them communicating via British Sign Language, Makaton, hand gestures and relying on a relative to support.

End of life care and support

- At the time of the inspection there were no people receiving end of life care. People's records did not have people's end of life wishes recorded. This meant that staff would not know how to support people if their condition deterioriated.
- People's resuscitation status was not always recorded. It meant people could receive inappropriate support in case of an emergency

The provider had repeatedly failed to ensure they provided people with person-centred care. This was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Continuity of staff allowed them to become familiar with people's personal choices. One staff member told us, "Our senior carers tell you this client needs this and needs this and shows you want to do. You get to learn what they want. When you are with them you get to learn from them."

Improving care quality in response to complaints or concerns
● There were no systems in place to record and identify trends in complaints. Complaints and concerns were recorded within a communication log amongst compliments and general enquiries
● The provider had systems in place to respond to individual complaints. People and their relatives we spoke with had not felt the need to raise any complaints, but they were aware of how to do so.
● The provider had a complaints, suggestions and compliments policy in place. We saw staff had been provided with an additional supervision meeting to address poor practice concerns.

Inadequate

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 inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At the previous inspection the provider had failed to protect people against the risk of receiving poor quality or unsafe care because the provider's oversight and scrutiny processes were not always effectively and timely managed. This demonstrated 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 registered manager was also the sole director of the provider. Their systems for identifying, capturing and managing organisational risks and issues remained ineffective. Some legal requirements were not being met or understood by the registered manager.
● The provider's own quality assurance processes failed to identify the issues we found at this inspection. There were no audits completed for care plans and risk assessments. We found errors in care plans and an absence of risk assessments where there were known risks. The medicine audits were duplicated and had not identified errors with the recording and safe administration of medicines which we identified at this inspection.
● There was no credible statement of vision and values, leadership at the service remained weak and there was no strategy or shared and realistic objectives.
● The registered manager did not always notify the CQC of incidents of serious harm. The local authority informed the CQC of safeguarding concerns they were investigating which had not been notified to the CQC by Winsor Care Services as per regulatory requirements.
● The registered manager demonstrated a caring nature but lacked competence in establishing effective systems for delivery. One professional told us "[The registered manager] as an individual is an amazing caring lady but she needs the infrastructure and support system in her company to be able to deliver the high-quality service she believes in."
● There was no evidence that staff competencies were being checked regularly. This meant the provider failed to reassure themselves the training provided to staff was effective.
● The provider had failed to send a Provider Information Return (PIR) to the CQC which was requested in November 2022. This is information providers are required to send us annually with key information about

the service, what it does well and improvements they plan to make.
The provider had failed to notify the CQC as per regulatory requirements. This demonstrated a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Continuous learning and improving care
● Information to support performance monitoring and making decisions was inaccurate and unreliable. We were told at the previous inspection that transferring records from paper to electronic systems was a contributing factor in the lack of monitoring. At this inspection this had not been resolved. This meant that inaccurate and unreliable information continued to result in increased risk within the service.
● The provider had continually failed to ensure records relating to people's care and the service they received were fit for purpose.
● The provider had not taken effective action to meet the breaches of the regulations identified at our last inspection. Despite submitting an action plan as a result of the last inspection, the outcomes had not been achieved and much of the areas of concern remained evident at this inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There was a limited approach to sharing information with and obtaining the views of staff and people who used the service. We saw evidence of outcomes from a survey, yet people and relatives told us they had not been provided with a survey. When asked if the service make contact to see if they are happy, one person told us, "No. I think if you're happy with the care you're getting, there is no need for them to phone." Another person told us, "Sometimes [registered manager] rings me."
● The provider had not gathered feedback from staff to establish any trends to inform changes or improvements to be made. Staff told us they had opportunities to speak to the registered manager individually about isolated issues. There was no overview of trends and patterns. Concerns we identified regarding staff feeling rushed had not been identified by the provider.

There was evidence that the poor quality of care had continued to result in harm to people and the quality of care had not improved sufficiently since the previous inspection. The provider had repeatedly failed to ensure good governance of the service. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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; Working in partnership with others

At the previous inspection the provider had failed to ensure that all relevant and necessary information was shared with relevant parties as soon as reasonably practicable to improve the care delivery when things went wrong. This demonstrated a breach of Regulation 20 (Duty of Candour) 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 20 with respect to the duty of candour.

● The provider was not transparent with people and relatives about incidents and accidents and failed to share the details relating to the investigation of them. Some relatives we spoke with were not aware of concerns about people's care we had seen records for. Other relatives who were aware, did not know about any investigation or consequential actions. There were no records of discussions with people or their families about incidents or accidents. When we asked how the provider had investigated an incident, one

relative told us, "That's all been sorted by the district nurses."

● The provider did not effectively collaborate with external stakeholders and other services. Information was not shared as required and there was little evidence of partnership working. One professional told us "Unfortunately [the registered managers] back-office system could be better and I have had to meet with [registered manager] about this and the quality of communication." Another professional told us, "We tried many times to make a meeting with Winsor to resolve our outstanding concerns but have not had any engagement from the management." This meant that there were delays to safeguarding processes and a risk that people would not achieve the outcomes they wanted.

● The provider failed to be reliably available and responsive via a direct and secure contact. We found that at least four e-mail addresses were used to correspond with the provider which obstructed the ability to work effectively in partnership with others. The registered manager told us that the local authority had been using an old e-mail address and so communication had not been reaching her. This had been a concern for many months and in an attempt to rectify this, the registered manager told us that two e-mail inboxes had been merged a week prior to the inspection.

We found no evidence that people had been harmed however, the provider had failed to ensure that all relevant and necessary information was shared with relevant parties as soon as reasonably practicable to improve the care delivery when things went wrong. This was a continued breach of regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.