Care Quality Commission

Thurlestone Court Limited

Windward House

Inspection report

Totnes Road
South Brent
Devon
TQ10 9JN
Tel: 01364 72386
Website: windward@seamoorcare.co.uk

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Windward House is a care home which provides accommodation and personal care for up to 42 people who may have care needs related to their dementia. People who live at the home receive nursing care through the local community health teams.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This inspection took place on 5 and 6 October 2015 and was unannounced. At the time of our inspection there were 37 people using the service. People had a range of needs with some people being independent and others requiring more support with their mobility and care needs. A significant amount of people who lived in the home were living with dementia.

Summary of findings

The service was last inspected in May 2014 and was found to be meeting all the regulations.

The service was not always well-led. People's care records were not always accurate and the quality assurance systems in place had not found a number of concerns identified during this inspection. We found concerns relating to risk management, mental capacity assessments, medicines management, the environment and stimulation for people. Feedback from people, relatives, visitors and healthcare professionals told us staff and management did their best to care for people in a caring way but we found the service did not provide an effective and caring environment for people living with dementia.

People who lived in the home were not always safe. People's medicines were not always well managed. For example, one person was dispensed medicines prescribed to someone else. It was not possible for the provider to assure themselves people were receiving their medicines as prescribed by their doctor. The home had procedures in place relating to disposing of medicines and conducting audits but these had not been followed.

Risks to people were not always well identified, assessed and managed. For example, one person had diabetes and required their blood sugars monitoring twice a day. Their readings fluctuated but staff did not have access to information about what the person's blood sugar range should be in order to maintain good health. This meant staff were unable to identify whether the person was at risk or if their readings were outside of the norm for them. After the inspection the registered manager consulted with a doctor who provided guidance for staff and undertook diabetes training.

Although staff and the manager felt there were enough staff to meet people's needs, people and their relatives did not always agree. This was particularly so at weekends and we have asked the manager to review this.

People were protected from abuse as staff had been provided regular training in safeguarding vulnerable adults. Staff knew how to identify abuse and how to report it should they have any concerns.

At least half the people who lived in Windward House had some degree of dementia. The environment was not suitably adapted for people living with dementia. For example, there was no signage to help people find their way around the home and the carpet caused people confusion. People did not benefit from suitable activity to promote their wellbeing. People spent long periods of time sitting in silence and relatives expressed their loved ones were bored.

Staff could not assure themselves that people were getting enough to drink as records were not accurate. People were not always encouraged to drink, for example, one person was provided with three drinks over four hours which were left untouched and removed by staff once they were cold. Staff did not encourage this person to drink. People enjoyed the food but did not feel they had a choice of meal. There were no menus and although staff asked people for their choice in the morning people did not have any memory of this. Staff supported people to eat and the chef catered for specific requirements.

The provider had not followed the principles of the Mental Capacity Act 2005 for those people who did not have the capacity to make their own decisions. Some people did not have mental capacity assessments in their care plans where these were required. It was not clear how people's care and treatment was carried out in their best interest where they lacked capacity to make decisions about their care themselves. The registered manager did not have a thorough understanding of the Deprivation of Liberty Safeguards (DoLS), they had not applied the 'acid test' to determine whether further application needed to be made to the relevant authority. The acid test is where a person is subject to continuous supervision and control and is not free to leave.

People were cared for by staff who had received a thorough induction and were provided with regular training, Staff received a yearly appraisal and regular supervisions.

People were not always treated with dignity and respect. For example, one person, who was proud of their appearance, was left in communal areas in their night clothes for four hours. For three of those hours they were placed in their wheelchair at a table facing the wall with no stimulation or companionship. When staff moved the person from that position they did so by pulling their wheelchair from behind without first speaking to the person or telling them what they were doing. On other

Summary of findings

occasions we saw very positive interactions between people and staff and people, relatives and healthcare professionals gave consistently positive feedback about staff.

Care plans lacked personalisation and many did not contain information about people's personal histories, their preferences, likes and dislikes. Staff, however, demonstrated they knew people well.

People and relatives had access to the complaints procedure and felt comfortable approaching the staff and the management with any concerns they may have.

Records were not maintained accurately, for example, one person had been living in the home for almost three weeks at the time of our inspection and did not have a care plan. Staff did not have instructions on how best to care for this person.

Audits had not always been carried out in order to identify possible issues. For example, a medicines audit had not been carried out and we found some discrepancies with quantities and disposal of medicines.

People, relatives, staff, visitors and healthcare professionals spoke very highly of the registered manager and felt they were approachable. Feedback was sought from people and their relatives in the form of questionnaires and meetings. Staff were asked for their feedback during meetings, handovers and supervisions.

We have made a recommendation for the provider to review their staffing numbers.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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.

People were not always protected from the risk of harm because risks were not always identified and managed.

Medicines were not managed safely and the provider could not ensure people were receiving the medicines they were prescribed.

People did not feel there were enough staff at the home, however, staffing levels were regularly reviewed in relation to people's needs.

People were protected from abuse because staff had received training in safeguarding, knew how to identify signs of potential abuse and the procedures to follow for reporting abuse.

Safe staff recruitment practices were followed.

Is the service effective?

Requires improvement

The service was not always effective.

The environment had not been adapted for people living with dementia to ensure the best possible outcomes.

Staff had not followed the Mental Capacity Act 2005 for people who lacked capacity to make particular decisions.

The provider was not able to ensure all appropriate applications had been made in relation to the Deprivation of Liberty Safeguards (DoLS).

Staff were provided with regular training and received regular supervision.

Is the service caring?

Requires improvement

The service was not always caring.

People were not always treated with dignity and respect.

People's confidentiality was not always respected.

People, relatives, visitors and healthcare professionals spoke highly of the staff and their caring attitudes.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not always responsive.

People were not provided with suitable activities throughout the day to keep them stimulated and promote their wellbeing.

People's care plans lacked personalisation.

Staff demonstrated they knew people well.

People and relatives had access to a complaints procedure and felt comfortable making complaints.

Is the service well-led?

Requires improvement 

The service was not always well-led.

Records were not accurate and kept up to date.

We found a number of issues during our visit which had not been identified by the provider's quality assurance process.

People, relatives, staff and healthcare professionals spoke highly of the manager and had confidence in them.

The provider sought people's feedback regularly and this was acted on.

Windward House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection visit took place on 5 and 6 October 2015 and was unannounced. The inspection was carried out by two adult social care inspectors, one bank inspector and one expert 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. Their area of expertise was care for older people living with dementia. Prior to the inspection we reviewed the information we had about the home, including notifications of events the home is required by law to send us. We used a range of different methods to help us understand people's experience. During the inspection we spoke with14 people who lived at Windward House, six relatives of people who used the service, the registered manager, one senior manager, four members of staff and three healthcare professionals.

We looked in detail at the care provided to eight people, including looking at their care files and other records. We looked at the recruitment and training files for four staff members and other records in relation to the operation of the home such as risk assessments, policies and procedures.

Requires improvement

Is the service safe?

Our findings

People were not always receiving safe care.

Risks to people were not always assessed and managed to ensure they received appropriate care and support. One person, who was living with dementia, regularly walked into other people's rooms during the night. According to their care records they had been displaying these behaviours for at least one month prior to our inspection. During our inspection we saw this person walk around the home constantly as well as going in and out of people's rooms. We did not see staff engaging with this person by offering any distractions or steering them away from people's rooms. We looked at this person's care plan and saw there was a record of this person being unsettled at night and wandering in and out of bedrooms. There was a care plan focused on night time care but there was no information about the person's wandering or how staff should respond to it. There was no risk assessment around the person entering other people's bedrooms in relation to potential risks to themselves or to others. The registered manager they told us staff ensured internal doors in the corridors were locked at night and the person was taking prescribed medicines to help them sleep, however the person's care plan had not been reviewed to include information about these behaviours or how staff should support this person and others affected by their behaviour.

Risks were not always managed to ensure people were kept safe. For example, we could not be assured that people were being given enough to drink. Where people had been placed on fluid charts these recorded that people were having as little as 340ml a day instead of their recommended 2000ml. No action had been taken to address these low fluid intakes or to ensure people were drinking enough. One person was observed, during a period of around four hours, being given three cups of tea during the first day of our inspection and each of these remained untouched before being removed by staff. Staff did not encourage the person to drink their fluids and simply removed the cups and replaced them with another. For this day, daily records stated this person had drunk 1400mls of fluid. During our four hour observation this person was not seen to drink any liquids. Staff were unable to tell us whether the untouched cups of tea had been added to this amount and whether the records were accurate. Without reliable and accurate documentation it would not have been possible for staff to accurately analyse risks relating to fluid intake, and may result in action not being taken.

One person had been assessed as needing their blood sugars monitored twice a day due to their diabetes. Records showed this person's blood sugar levels varied between 4mmols and 14.5mmols (this is a unit of measurement relating to blood sugar levels). There was no information in the care plan about what an appropriate range for this person was and how staff should interpret or act on this information. This means the staff would not have been able to identify if this person's blood sugar reading was in their healthy range or whether action needed to be taken to address the risk. Staff confirmed they did not know what the person's recommended levels were. We spoke about this with the registered manager and they made immediate contact with the GP who later visited and provided guidance.

People who were at risk of weight loss had also not been weighed regularly. Three people whose care records we looked at had been assessed as requiring their weight being taken monthly. Staff and the registered manager told us this had been due to the scales owned by the home not being in working order. They told us it had taken over three months for the scales to be repaired and they had not been able to weigh people in the meantime. Windward House is part of a group of four homes owned by the same provider, located in Devon. The registered manager told us Windward House owned their own set of scales and these had broken. They also told us the group of homes also owned a set of scales which were shared between the four homes and available for use but there had been a lack of proactive action in obtaining these. A senior manager told us had these been requested by staff at Windward House these would have been provided.

People's risk assessments were not always updated to reflect changes and care plans did not always contain up to date information. For example, one person had been assessed as being at very high risk of pressure ulcers due to their low BMI, however, their malnutrition universal screening tool (MUST) had not been updated to reflect this and was blank.

People's medicines were not always well managed. When dispensing medicines staff frequently left the medicine's trolley unlocked and un-monitored. The member of staff

administering medicines left the room on a number of occasions during our observation leaving the trolley open and accessible. This meant that it could be possible for someone to access the medicines in the trolley. Medicines were placed into individual pots which were given individually to people. However, on one occasion these were left by a person's plate during breakfast and staff did not remain to observe the person taking the medicine. This meant staff could not be sure that the person did take their medicine and that no one else took it.

We looked at medicine administration records (MAR) for two people. One person had been prescribed two medicines to be taken at 8am every day. Staff told us one of the medicines was an "important medicine" for the person's heart condition. Records showed that on a number of occasions the person had refused this medicine and on those occasions staff had not been offering the medicine again at a later time. This meant the person had not taken the medicine prescribed for their heart condition for a number of days leading up to our inspection. This was confirmed when speaking with the member of staff dispensing medicines. The person's GP had not been contacted about this. During our inspection the person was offered their medicine again and they took it. We spoke with a senior member of staff who told us they would be instructing staff to offer the medicine again at a later time should the person refuse it in the morning.

Two people were prescribed the same medicine. We observed staff using the medicines of one person to give to another person. As staff were giving people other people's medicine supply, it was impossible to check each person had received their medicine as prescribed. Records relating to the medicines in stock were not accurate and we also found loose tablets which had not been disposed of properly. This meant it was not possible to evidence whether people had received their medicines as they had been prescribed by their doctor to promote good health.

This was a breach of Regulation 12 (1)(2)(a)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told eight members of staff were authorised to administer medicines and all had received training to do so. One senior member of staff had overall responsibility for ordering the medicines and this was done according to the home's policy. Medicines that required more robust monitoring were stored and managed correctly. In addition to the home's register for these medicines we were shown a second register. Staff explained that this was for the district nurses to use together with end of life medicines. We did an audit of both registers against the medicines in the safe and found them to be correct.

When asked about staffing levels people who had less care needs thought there were sufficient staff, but people who had a high level of need disagreed. People said "There's a shortage of staff all of the time", "They are short staffed. The quickest they respond to the call bell is about ten minutes, one day it was 30 minutes and it has been longer than that", "Sometimes I ring the bell and it takes a while for them to come, once up to an hour" and "I've got used to it but the bell takes a long time. They're very short staffed".

Most relatives we spoke with felt the staffing numbers were sufficient but one said "Now and again it's low on staffing, weekends you barely see anybody" and another said "Staffing at the weekends is too low".

During our inspection we saw that there were a number of staff caring for people and call bells were answered quickly. We did not, however, see staff engaging in conversations or activities with people. Staff seemed fully occupied with the routine of care tasks and seemed to lack flexibility. People spent long periods of time in the lounge without a member of staff in the room to reassure people or to ensure they were safe. For example, one person spilled their cup of tea in their lap during our observation. We observed that when staff did enter the room this was to perform a specific task, such as giving people drinks or bringing a person into the room. One relative who visits the home regularly told us they were concerned about the lack of staff in the lounge.

The registered manager told us staffing consisted of six care workers, two cleaning staff, one kitchen assistant, one cook and one handyman. They told us weekend staff consisted of seven care workers, the cook and the kitchen assistant. They told us they were always looking at the needs and numbers of people who lived in Windward House and adjusted staffing levels accordingly. The registered manager gave us an example where staffing levels had changed following a change in the support people needed with eating and drinking. They also told us they were on call at weekends and had conducted pop ins during weekends and nights to check on staff performance and staffing levels.

Requires improvement

Is the service safe?

Staff told us there were usually enough staff on duty at all times. They said it would be ideal if there were more staff but not essential. One member of staff said "Sometimes it's short staffed but that's when there's sickness". When staff phoned in sick the registered manager would try to get another member of staff to cover. When agency staff were used staff always tried to ensure consistency.

People and their relatives said they felt safe and secure at the home and they trusted the staff to care for them. Healthcare professionals told us they had no concerns about people's safety and thought people received high quality care. One healthcare professional said "I have no concerns, certainly no concerns around safety".

Systems were in place to ensure people were protected from abuse. Staff were able to tell us how they would recognise signs of abuse. Staff knew how to raise concerns about abuse and poor practice. They felt the registered manager would listen to any concerns they had and respond to these. Staff were provided with contact details for external agencies they could contact and were provided with safeguarding training every 18 months. The home had an easily accessible safeguarding policy as well as a whistle blowing policy. People were protected from the risk of unsuitable staff because the service had appropriate recruitment systems in place. The service had taken steps to ensure staff were of good character, and had appropriate skills, knowledge and qualifications to carry out their role.

Accidents and incidents were monitored to minimise the risk of reoccurrence. For example, the registered manager had arranged for a person to be seen by the physiotherapist following a fall. The physiotherapist had then given staff advice on how best to assist the person to avoid falls and this had been implemented by staff. The service had emergency procedures in place and people had personal emergency evacuation plans in place.

We recommend that staffing levels are reviewed to ensure there is sufficient staff to offer support to people at all times, including weekends, and ensure people's emotional needs are met at all times.

Requires improvement

Is the service effective?

Our findings

The home was not effective.

The environment was not suitably adapted for people living with dementia. For example, the corridors and furnishings were very bland in colour and there was no visual signage to assist people in finding their way around the home easily. The registered manager told us people with dementia had photographs of themselves on their bedroom doors but they did not have their names or other visual aids. The photographs were of people at the age they were at the time they moved into Windward House and therefore people living with dementia may not have recognised themselves. This made it very difficult for people to find their way around and did not help people feel confident about their surroundings, or relieve anxiety. For example, we observed one person sitting in the dining room for over two hours. During this time we heard them repeat several times "I don't know where I am". It was clear they did not know where to go as several times they asked a staff member where their room was. The staff member told them but the person did not know how to follow the staff's instructions and stayed sitting at the table until a member of staff actually showed them the way to their room.

The home had a highly patterned carpet which was not suited to people living with dementia. We observed a number of people being worried about the carpet. For example, one person hesitated and expressed worry about going down the stairs because of the carpet. We observed another person trying to pick up the flowers on the carpet pattern. This choice of flooring was unhelpful for people with dementia or other health issues that may affect vision or the inner ear. This did not show understanding for people's diversities and the home's environment did not suit people's needs. The registered manager told us staff had received dementia training but knowledge of dementia was not evident in the environment. We discussed this with the registered manager at the time of our inspection and they told us the provider would look into the possibility of installing signage to assist people.

This was a breach of Regulation 15 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's nutritional needs were not always well managed. We observed people being served their breakfast on the first day of our inspection. People were waiting for some considerable time for their breakfast to be served. The dining room where most people were having their breakfast had a window which looked out onto the car park. For the first hour of breakfast service the blind on this window remained down which made people confused, one person stated it must be snowing outside and another stated it must be very misty.

People's individual preferences around food were not being attended to. People spoke highly of the food at the home but told us they did not have a choice of the food they ate. People said there was no choice at lunchtime and they were not asked what they would like. There were no menus displayed in the home. The chef told us staff showed people a list of options during the morning tea round and asked people what they wanted. We saw there was a choice of main meal for lunch as well as a vegetarian option, however people did not seem to know this. One person said "There is a vegetarian alternative but no one tells you what it is. I did have it once and it was really good but I'm not asked about it". Several people said they did not know what would happen if they didn't eat the food they were offered and they just had what they were given. One person said "Normally there's no choice of food. I have the same meals as the rest".

Records relating to people's eating habits, weights and food related issues were not always accurate, but staff were taking steps to ensure people had enough to eat. For example, one person had lost weight and was having difficulty eating. Staff changed the cutlery the person was using and assisted the person with their meals in the activities room instead of the dining room as it was less distracting. Staff told us these steps had made the person start to eat more.

Some people had specific dietary needs. The chef had been trained to cater to those needs. For example, where people had a pureed diet, the different elements of the meal were set out on the plate. Where people were at risk of losing weight, the cook prepared enriched foods, which included adding cream and butter to them. Food was cooked on site daily and was of good quality. People could ask for food throughout the day and night. Where people required staff support to eat we saw this was done in a calm and caring way and people were not rushed.

Requires improvement

Is the service effective?

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 Act 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.

The provider had not followed the principles of the Mental Capacity Act 2005 for those people who did not have the capacity to make their own decisions. For example, we looked at the records for one person who was living with dementia and may lack capacity in certain areas. The registered manager told us this person needed help to make all their decisions. There were no mental capacity assessments in this person's care plan. Therefore, it was not clear how their care and treatment was carried out in their best interest, or whether they had the capacity to consent to care or refuse this. There was no information in the person's care plan about how staff should gain this person's consent and there was only a best interest decision record relating to this person's medicines which involved the GP. During our inspection we saw staff moving this person in their wheelchair without gaining their consent or speaking to them at all. A second person had been assessed by a mental health practitioner as lacking the capacity to make a decision about where they lived. Within this person's records was a record of a best interest decision having been made in regards to night time observations. No other considerations of the person's capacity had been made. Another person had been assessed as requiring a bed rail and did not have capacity to make decisions. There was no mental capacity assessment or best interest decision involved in the fitting of the bed rails.

This is a breach of Regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they were going to be submitting two applications to the supervisory body for authority with regards to Deprivation of Liberty Safeguards (DoLS). The registered manager did not have a thorough understanding of the Deprivation of Liberty Safeguards (DoLS). They were not aware of changes to DoLS due to supreme court judgement. The registered manager told us some people were unable to leave the home and were subject to continuous supervisions and control. The registered manager was unable to tell us whether all people who were being deprived of their liberty in this way had been identified and that applications had been made to the relevant authority. It was therefore not possible for them to assess whether people were being deprived of their liberty without the legal authorisation to do so. This was discussed with the registered manager and they told us they would be seeking further knowledge in order to assess whether further applications were needed.

People received prompt medical attention and staff sought the opinions of healthcare professionals. One visiting healthcare professional said "The manager is quick to call us, our advice is followed and they are prompt with calling". Another healthcare professional said "I get called appropriately and my advice is followed by staff".

Staff told us they were happy with the training they had received and felt skilled to meet the needs of the people in their care. Staff undertook regular training which was kept up to date to make sure they knew how to meet people's needs. Upcoming training courses were made available for staff to attend, for example, in the weeks following our inspection medicine management, manual handling and fire safety training was taking place. Additional training had been put in place for three members of staff to take part in a specific end of life training package. The registered manager told us this learning would then be shared with the wider staff team in order to benefit people as much as possible.

There was a comprehensive induction programme which included face to face training, shadowing and observations. Staff were encouraged to complete diplomas in social care. Staff had regular supervision and a yearly appraisal. During supervision, staff had the opportunity to sit down with their line manager and talk about their job role, discuss any issues, training needs and development opportunities. One member of staff said "I got support to become a senior. I get supervisions and appraisals".

We recommend the provider researches and implements guidance for supporting people with dementia in an enabling environment.

Requires improvement

Is the service caring?

Our findings

The home was not always caring.

People spoke highly of the care they received from the staff, who they described as kind, helpful, cheerful and friendly. People were full of praise for the staff and said their privacy and dignity were respected. We saw many examples of positive and supportive care being delivered from staff, but we also one instance where people were not always treated with respect and dignity.

When we first arrived at Windward House on our first day of inspection at 7am we observed one person sitting in the dining room. This person was sitting in a wheelchair, at a table, facing a blank wall. Their chin was level with the table top and they were sitting on their own with nothing in front of them. They were wearing their nightclothes, a dressing gown and slippers. We observed this person sitting in the same position for three hours and 13 minutes, until a member of staff entered the room, walked up to the person and pulled them backwards away from the table with no warning or communication about this. This person was then taken into the lounge, still in their wheelchair and nightclothes and was placed in a position where they could not see the television. At 11.50am this person was wheeled into a small shower room. A trolley containing the person's underwear was left outside the door in a public hallway. We observed staff opened the door to retrieve items from the trolley and it was possible to see the person in a state of undress at this point. We looked at this person's care plan which stated they were a smart person who took pride in their appearance. The care plan also contained a letter from the person's loved one which emphasised how important personal grooming and presentation was to the person. Staff told us this person had remained in their bedclothes that morning because it was their 'shower day' and that on other days they would have been dressed sooner.

This was a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On other occasions, however, we observed staff displaying caring attitudes towards people. For example, we observed one person wearing very short night clothes walking into a communal area. Staff tried, with great tact, to assist this person to maintain their modesty. We also saw that most people in the home looked well dressed. The hair dresser visited regularly and there was a hairdressing room in the home. Some people were visiting the hairdresser on the first day of our inspection.

People's confidentiality was not always respected. For example, a noticeboard in the activities room was being used to remind staff about people's needs. This meant people's names and their needs relating to eating and drinking and repositioning were displayed in a communal area. We raised this issue with the registered manager who told us this confidential information would be removed without delay. The registered manager confirmed this had been done following our inspection.

The feedback we received from people who lived in Windward House, their relatives, visitors and healthcare professionals was consistently positive. People said "They're good staff and a very high standard of service", "It's lovely, the family know I'm being looked after and it's a lovely lot of girls", "I think it's a wonderful place, the staff make him feel comfortable and he's very well cared for", "The staff are always brilliant" and "They've always shown kindness, patience and compassion". One visitor said "The philosophy of the place is to give kindness and compassion to people and they do it very well".

People's rooms were specious and some had very pleasant views. There were various lounges and different spaces where people could wander freely. Relatives and friends were welcome at any time and people had daily newspapers if they wished as well as televisions, radios and mobile phones so they could be in touch with loved ones.

Requires improvement

Is the service responsive?

Our findings

The home was not always responsive.

Care plans did not always reflect people's needs. The amount of detail contained in people's care plans was variable, with some containing very little. For example, one care plan did not contain any medical history information, no information about the person's preferences with regards to activities or food and lacked a number of necessary risk assessments.

Records relating to people's care were not always updated and reviewed appropriately. A number of records were not accurate or kept up to date. For example, one person had been assessed as requiring two hourly repositioning due to having a pressure sore. This was not being reflected in the recording where there were significant gaps. This person's pressure sore was healing, however, and staff told us they were repositioning them every two hours. The pressure sore had not developed in the home and staff had involved the relevant healthcare professionals to care for this. Another person had lived in the home for almost three weeks but did not have a completed care plan. Staff did not have access to information about how to care, support or reassure this person.

People did not benefit from individual activity plans to ensure they had meaningful activities to promote their wellbeing. The provider had not used information about the person's life, their interests and their abilities to develop individual ways of stimulating and occupying people. People told us about various activities they had taken part in and the visitors who came to the home. For example, people could receive communion regularly and a music group came in regularly. People also went out in the home's minibus weekly to visit local beauty spots. However, people were not sufficiently stimulated throughout the day. People spent a lot of time sitting in silence or sitting in the conservatory watching the television. Activities were focused on the activities room and the activities person who was performing another role at the time of our inspection, there were no objects around the home people could interact with or frequent daily activities. The activities room was a good space and there was evidence of craft work having taken place. However, there was no evidence of activities available for people living with dementia; there were no memory boxes or artefacts, no recreations of rooms resembling people's experiences in their own homes or during their lifetimes. There was nothing for people to pick up and handle throughout the home. This type of stimulation can improve mood, encourage people to talk with others and take part in daily activities.

This was a breach of Regulation 9 (1)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had sought sensory objects sewn by a local charity and these were delivered to the home on the second day of our inspection. The registered manager listened to our feedback and told us they would be making the objects available for people to interact with throughout the home.

Care plans lacked information about people's personal histories, interests, likes and dislikes. The home worked with a specific document staff were to complete about the person which included details of their past histories and things that were important to them. Most of the care plans we looked at contained either a blank document or none at all. Where we did see this document we found information relevant to the person had not always been included in the document. Staff did, however, demonstrate that they knew people well. People were also matched with a key worker who was matched by taking into account their personalities and their interests. We found each person's care plan named a particular member of staff as being that person's key worker.

People and their relatives had access to the complaints procedure. No-one recalled making any complaint but said they would be confident to speak to members of staff if they had one.

Requires improvement

Is the service well-led?

Our findings

At the time of the inspection the provider's quality assurance processes had not found some the concerns identified at our inspection.

At our inspection we found records relating to people's care were not regularly reviewed and a number of records were not accurate or kept up to date. This included care plans and risk assessments. The registered manager told us they were in the process of introducing a new system relating to care plans in which a monthly review of the care plans would be undertaken by people's key workers. This had not yet been introduced at the time of our inspection.

Medicine audits had not always been carried out. Staff told us they usually carried over any unused medicines and added these to the medicine administration record (MAR) sheet, however, this had not been done this month. It was therefore not possible to carry out an audit on the medicines with any confidence that it would be correct.

This was a breach of Regulation 17 (1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had recently implemented a new system for assessing the quality of staff performance and had incorporated observations of personal care at every supervision. Staff's training needs were regularly reviewed and their knowledge regularly tested. Windward House was part of a group of four homes. A senior manager told us how learning from one home would be shared amongst the different homes in order to generate improvement.

People, relatives, staff and healthcare professionals all spoke very highly of the registered manager. One person said the manager was "Excellent" and staff said the manager was "Brilliant" and "Fair". One visitor referred to the registered manager as "A great inspiration". A healthcare professional said "A good home has a good person at the top and that is (name of manager)".

People felt the registered manager was approachable and they could raise concerns with them. One person said "The manager is very proactive, always ready to listen to advice or opinions". Relatives told us they felt the manager was approachable and would listen to their feedback. For example, one relative said they had brought an idea to the registered manager about volunteers being given a health and safety book and this had been implemented. Staff said the manager was approachable and would listen and act on any feedback they had. Staff feedback was sought during staff meetings, handover and supervisions. One staff member had recently made a suggestion about changing a person's mattress and this was being arranged.

People's feedback was often sought in the form of residents questionnaires and resident meetings. Their feedback was then acted on, for example, people had said they would like more fresh vegetables and the chef had organised for this to happen. Relatives' feedback was also sought in the form or relatives questionnaires.

Staff and visitors talked about the home's ethos. They described it as being about making people happy and comfortable and keeping their individuality. Staff told us the registered manager was always promoting this ethos by regularly observing staff performance and ensuring they cared for people to a high standard. One healthcare professional said the manager was very good at ensuring staff demonstrated the home's ethos, they said "The manager is on the case of the staff and is totally well meaning".

A senior manager told us how they sought training from external sources in order to keep up to date with best practice and improve knowledge. There were plans for staff to undertake further training in palliative care and five members of staff had undertaken verification of death training provided by the ambulance service. They also told us registered managers for the four homes owned by the provider would be undertaking culture training delivered by an outside agency. They felt this would help improve the service.

The registered manager had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How this regulation was not being met: People's care and treatment did not reflect their preferences and did not appropriately meet their needs. Regulation 9 (1)(a)(b)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: People were not always being treated with dignity and respect. Regulation 10 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The provider had not followed the principles of the Mental Capacity Act 2005 for those people who did not have the capacity to make their own decisions. Regulation 11 (1)(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Risks to people were not being assessed, care was not being provided in a safe way for people and medicines were not managed safely. Regulation 12 (1)(2)(a)(b)(g).

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: The premises were not suitable for people living with dementia. Regulation 15 (1) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not assess, monitor and mitigate risks or improve the quality of the service provided. Regulation 17 (1)(2)(a)(b)(c).