Dr I P Vinayak and Dr V Vinayak

Windsor Care Home

Inspection report

Victoria Road East
Hebburn
Tyne and Wear
NE31 1YQ

Tel: 01914301100

Date of inspection visit:
27 October 2020
28 October 2020
02 November 2020
18 November 2020

Date of publication:
14 December 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Windsor Care Home provides residential and nursing care for up to 60 people. At the time of inspection, 30 people were using the service.

People's experience of using this service and what we found
People did not always receive safe care. Issues were identified with the cleanliness of the service including infection control procedures. Staff did not always adhere to government guidelines regarding the correct use of PPE. People were not always protected from abuse.

There was a lack of both environmental and personal risk assessments for people. The premises were not safe for people living at the service. Some people did not have access to emergency call bells in their bedroom. Staffing levels were not at an appropriate level to care for people safely or to meet their emotional needs. Areas of the service were not dementia-friendly and were in need of refurbishment.

People's medicines had not always been managed safely. Elements of people's care plans had not always been reviewed and for one person extensive parts of their care plan was missing. Capacity assessments had not always been completed for people or best interest decisions made, for example where people's bedroom doors were kept closed.

Records lacked detail regarding the monitoring of some people's daily fluid targets. People did not always have access to the food of their choice. Food portion sizes and the variety of food on offer was not always appropriate. People had not always been referred to other healthcare professionals in a timely manner, in particular in relation to substantial weight-loss.

People were not always treated with dignity or respect in relation to their clothes and appearance. The majority of people's bedroom doors were closed without reason and some of those people were heard to be calling out for assistance..

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

During this inspection, staff appeared very task-orientated and very little caring or emotional support interactions with people were observed.

People we spoke with told us they liked living at the service and one person told us, "I like my room. I used to be in a different room which was dark, and it was difficult for me to see. I changed to this room and it is much better. The girls are lovely."

The manager and the provider were open and honest with the inspectors during and after the inspection process. They acknowledged the concerns which had been highlighted to them and are currently taking action and working towards resolving the issues. This action has included employing new staff, the creation of additional roles and involving an external consultant to assist the management team in identifying and assessing the quality and safety in the service.

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

Rating at last inspection
The last rating for this service was good (published 20 December 2018).

Why we inspected
We initially visited this service to carry out a targeted inspection of infection control procedures. However, after the first day of inspection we received concerns in relation to staffing levels and the safety of people living in the service. As a result, we carried out a comprehensive inspection to review all five key questions of safe, effective, caring, responsive and well-led.

We found evidence the provider needs to make improvements. The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection. Please see the safe, effective, caring, 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
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to person-centred care, dignity, consent, safe care and treatment, safeguarding, premises, governance and staffing at this inspection. We have also made four recommendations.

The provider had also failed to notify CQC of certain incidents and accidents which had happened in the home. This was a breach of regulation.

Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore 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 six 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 rating 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 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring,

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Windsor 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 Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of two inspectors.

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

The service had a manager in post. This manager had been in post since the beginning of October 2020, but they were not registered with the Care Quality Commission. They told us they would apply for registration imminently. A registered manager is someone who, along with the provider, is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This supported the home and us to manage any potential risks associated with COVID-19.

What we did before the inspection
We reviewed information available to us since the last inspection. This included details about incidents the provider must notify us about, such as abuse. We sought feedback from commissioners and professionals

who work with the service, including the local authority safeguarding adults' team.

During the inspection
We spoke with two people, the manager and the providers and we reviewed a range of records. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We reviewed a number of care records, and continued to receive information from the manager and the provider to confirm the inspection findings. We also spoke with the maintenance staff, a nurse, 10 care staff and two domestic staff.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection
• Infection control procedures in place were not robust enough to keep people safe from infection. One person was living in isolation due to a recent discharge from hospital. There was a lack of appropriate signage to inform staff this person was to be cared for in their room.
• We were not assured staff were using PPE effectively. Some staff were observed not be wearing their PPE as instructed or failed to wear the correct level of PPE. There was a lack of signage within the service to support staff to adhere to PPE guidelines.
• Unused PPE was not stored appropriately. For example, rolls of unused aprons had been placed on tables around the service. This posed a risk of contamination.
• Areas of the service, for example people's bedrooms, their en-suites and general storage areas were in need of a thorough clean. In some areas of the service, clean laundry had been placed in inappropriate areas. For example, clean towels and face-clothes had been placed across a clinical waste bin in a communal toilet and stored on tables and open shelving units on the landing areas on the first floor.
• Daily cleaning rotas where in place but had gaps across various dates. We could not be assured regular cleaning of the service had taken place.

Infection control systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment.

• Staff did have access to PPE including gloves, aprons and masks to help prevent the spread of infection.
• The provider had a process in place to test both people living at the service and staff members on a regular basis for COVID-19 infection.
• The provider was in the process of building a visitor's pod. This would allow people to visit their relatives safely, whilst adhering to COVID-19 guidelines, for example around social distancing.

Assessing risk, safety monitoring and management
• Risks to people's health and safety were not always assessed or managed safely. For example, two people who had been diagnosed with diabetes did not have a diabetes risk assessment in place. One person who had a catheter in place did not have a catheter care plan or risk assessment in place.
• Some people had been assessed as requiring specialised mattresses to support their skin integrity. Upon review of these mattress settings, it revealed a number which were set at the incorrect level for people's weight.
• Some areas of the premises were unsafe for people. People with fluctuating capacity had access to unsafe

areas and items including storage rooms, razors, scissors, a boiled kettle, the sluice room and chemicals.
• One person chose to have their bedroom door locked. When inspectors asked where the key was stored to open the door, the member of staff present (only member of staff in this area), was unable to find it.
• The fire risk assessment had not been reviewed on an annual basis as per the provider's own fire policy.
• First floor windows within the service were found to exceed safe opening requirements.

Risks to people had not been fully assessed. This placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment.

We spoke to the manager who took immediate action to address the above issues.

Using medicines safely
• People's medicines were not managed safely. For those people who could not verbalise their pain, there was a lack of as required medication protocols (PRN) within their care plans. PRN medication is medication which is given to people as and when they require it, for example if they are in pain.
• For two people who did have PRN protocols in place, documents did not include the date the protocol had been implemented nor a date when the PRN medication should be formally reviewed. In addition, where PRN medication had been given, staff had not always fully recorded this.
• Some people's medication charts for prescribed creams were missing
• Some people had prescribed thickeners added to their fluids to prevent them from choking, but there were no records for staff to follow detailing how much thickener should be added.
• The provider had failed to follow their own medication policy. One person's hand-written medicine chart only contained one signature. This was contrary to the provider's own policy and national best practice guidelines, which states two signatures are required when creating hand-written medicine charts.
• The provider's medication policy was out of date. The policy was dated March 2017 but should be reviewed yearly. In addition, the policy did not include any reference to the safe handling of controlled drugs.
• Not all staff who administered or supported people to take their medicines had received appropriate competency assessments.

Systems for managing medicines were not safe or in line with national guidelines. This placed people at risk of harm. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment.

Systems and processes to safeguard people from the risk of abuse
• People were not always protected from abuse. During the inspection, people were heard to be calling out from behind closed doors and some of these people did not have access to call bells.
• One person who was in isolation, did not have a plan in place to say how they would be supported.
• Safeguarding incidents were not always fully investigated

People were not always safeguarded from potential abuse. This placed people at risk of harm. This is a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safeguarding service users from abuse and improper treatment.

• Safeguarding issues had been logged and notified to the local authority. Staff told us they were confident to identify signs of abuse and were able to tell us the steps they would take to notify the appropriate people.

Staffing and recruitment
• Staffing levels were not at an appropriate level to support people's safety or their emotional well-being.

During the inspection, staff were noted to be absent from one area on the first floor. Three people were living in this area, one of whom was living with a dementia and required staff presence to support them safely.
• One person we spoke with told us they had been up, dressed and out of bed since 5am that morning. They told us they had rung for assistance during the night. The member of staff who had supported them with their personal needs, had suggested getting changed out of their nightwear and into their day clothes in order to help day staff. The person said it helped the staff if they got ready early, but it made it a long day.

There were not sufficient staff deployed. This placed people at risk of harm. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing.

We spoke to the manager and the provider on the second day of inspection and they urgently arranged for an increase in additional staff for both day shift and night shift.

• We asked one person if staff responded to their requests for assistance, they told us, "Depends on how busy they are."
• Staff recruitment was safe.

Learning lessons when things go wrong
• Incidents and accidents were recorded and reviewed. However, a review of the analysis carried out did not support any learning in terms of actions to be taken to prevent re-occurrence. For example, a lot of people's falls were unwitnessed. No analysis had been carried out to identify, times of the falls, staffing levels or environmental issues which may have been a contributing factor.

We recommend the provider review this process immediately to ensure a robust protocol is implemented regarding sharing of information with staff and to embed lessons learnt as a result.

Inadequate

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet
• People's weights had not always been closely monitored. One person received their food via a percutaneous endoscopic gastrostomy (tube into their stomach). They had lost a considerable amount of weight. For this person and others, timely action had not been taken to refer these people to other healthcare professionals for their input and advice.

People had not been referred to other professionals regarding their weight-loss. This placed people at risk of harm. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment.

The manager has since taken urgent action to refer people to the appropriate healthcare professionals for their input.

• Some people's fluid target charts were either missing their fluid target, or they had not been totalled on a daily basis to identify if people had not met their daily target. Where people had failed to reach their daily target, no instruction was recorded to guide staff of the action they should take, for example to encourage fluids or refer people to their GP.

People's target fluid intake had not been monitored. This placed people at risk of harm. This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance.

• During inspection, one person was overheard to ask for fish-fingers for their lunch. Staff said there was not enough fish-fingers left and had to half one person's fish-fingers with another person to support this request.
• A review of people's daily food and fluid charts revealed finger foods were often served as a tea-time meal without a hot-food alternative.

We recommend the provider undertakes a review of their current menus to allow greater availability, more choice, and seasonal appropriate food.

• People told us they had access to snacks and drinks throughout the day. One person told us, "Oh yes the girls will bring me a cuppa if I ask."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live

healthier lives, access healthcare services and support
• People had in most cases been referred to other healthcare professionals, for example, optician appointments and contact with the local mental health team.
• People told us they had access to other healthcare professionals to support their well-being. One person told us they had seen their podiatrist the previous week and another person told us staff would contact their GP on their behalf. However, people's care plans did not always include details of this.

Staff support: induction, training, skills and experience
• Training for some staff was either not up-to-date, or staff had not received training to care for people safely. For example, staff were out of date with training in fire, moving and handling and training specific to the individual needs of people.
• The fire alarm test documents completed in August 2020, included a recommendation regarding the need for night-shift staff to undergo refresher fire training. This training had not been carried out for some staff.

Staff had not always received appropriate training or refresher training to allow them to care for people safely. This placed people at risk of harm. The above is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing

• During the inspection several shortfalls were identified in staffs' approach to people's dignity, supporting people's emotional needs and supporting people to eat.

We recommend the provider urgently undertakes a review of their training topics to ensure topics covered include all aspects of people's health and emotional needs.

• Those staff we spoke with told us they had received training and were very enthusiastic about their training. Some staff told us they had recently completed their Level III Diploma in Health and Social Care.
• People told us staff had the right skills to care for them, one person told us, "The girls are marvellous, they chat to me when they come in, but I could do with a little bit more company."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Care plans were not always up-to-date or reviewed on a regular basis. For one person who had been admitted to the service over a month ago, an extensive amount of their care plan had not been completed.
• One person we spoke to told us they suffered from a particular condition which meant they needed a specialist chair to support with their comfort. We asked them if they had spoken to staff about sourcing this new chair. They told us they had, but had been told no, and this was due to the cost involved.
• One person told us they had lived in the service for a number of weeks and they had not had a shower. They told us they had been washed in bed since arriving at the service. We asked this person if they would like a shower and they told us, "Yes, but no one has asked me."

People needs had not always been fully assessed or personal preferences actioned. The above is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Person-centred care

We spoke to the manager regarding the above concerns which were raised with us and they agreed to look into these matters.

• Other care plans seen did include people's preferences. For example, how one person liked to have two pillows on their bed, how they liked a cup of tea before bed and how they had no preference regarding a male or female carer to support them with their personal care needs.

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 Act requires, 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 and whether these principles were being met.
• The provider was not working in line with the principles of the MCA. Capacity assessments had not always been completed where there had been a change in people's capacity, including appropriate best interest decisions. We spoke to the manager who told us they felt capacity assessments were missing from a lot of files.
• Where people did have capacity, some elements of some people's care plans did not include people's signatures to indicate they had been involved in their care planning.
• The majority of people's bedroom doors were closed. People were heard to be calling out for assistance behind these closed doors. The manager was unable to provide an answer as to the reason why these doors were closed. In addition, no information was recorded in people's care plans to evidence where discussion had been held with people, or best interest decisions taken to support this practice.

People's needs had not always been fully re-assessed when a change in their needs occurred. The above is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Need for consent

Adapting service, design, decoration to meet people's needs
• Large parts of the premises were not dementia-friendly and did not support people who were living with a dementia. Corridors and bedroom doors were painted in the same colour making it difficult for people to orientate themselves. Some people (without dementia) told us they had chosen to have their bedroom doors locked as quite often people would walk in, unsure of where they were.

We recommend the provider adopts a scheme of refurbishment to support a more dementia friendly environment.

• People had access to both private and communal areas where they could choose to spend their time. People also access to an outside garden area.
• People's rooms had been decorated with personal belongings and were comfortably furnished.

Inadequate

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence: Ensuring people are well treated and supported; respecting equality and diversity;
• People's dignity was not always maintained. During inspection, we found people were inappropriately dressed which compromised their dignity.
• One person was receiving treatment from a visiting healthcare professional. Their bedroom door had been left open which meant people walking past could see directly into their room. In addition, this person was calling out. Inspectors had to ask staff to support this person. This person's care plan was later reviewed and included information instructing when this person received care from an external professional, staff must be present to support them.
• Staff were observed to be very task-orientated, with very little verbal interaction with people. For example, staff were seen to place food in front of people without any communication and then walk away. Staff did not ask people if this food was their preferred choice. They did not show or tell people what the food was in front of them.
• One staff member was seen to be supporting one person to eat. During this time, the staff member only spoke to this person to say their name. They did not stimulate or engage with this person. The staff member placed food onto a fork and raised it to the person's mouth without any explanation. In addition, this person was not encouraged or prompted to take a drink.

People were not always supported to maintain their dignity and respect. The above is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Dignity and respect.

• We received mixed responses regarding people having choice regarding their care. One person told us they could choose what time they wished to go to bed, and whether they remained in their own room or sat in communal areas. However, another person who had recently been admitted to the service, told us they had not been offered the opportunity to go along to the communal lounge areas to engage with other people.

We spoke with the manager regarding this and they took immediate action to speak with this person.

Supporting people to express their views and be involved in making decisions about their care
• No information was available to review regarding how people felt about the care they received.
• Information about advocacy services was available in the main reception area but this was not accessible to people living at the service.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support
• People's care was not always planned to meet their needs and preferences. Although some care plans documented people's preferences and wishes, this was not done consistently.
• Some people had specific health needs, however care plans were not always in place to guide staff. This meant staff did not have the information they needed to ensure people received safe care and treatment.
• Other care plans for people with more complex medical needs lacked detailed information to guide staff about how to care these people safely.
• Staff did not have up-to-date information about some people's care preferences, as care plans had not been kept up-to-date as people's needs changed.
• Care plan review records lacked meaningful information about whether people's care was still relevant to meet their needs.
• People did not have the opportunity to discuss their future care wishes.

The provider had failed to ensure some people received personalised care. This placed people at risk of harm. The above is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centred care

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People were not supported to participate in regular activities which were meaningful to them.
• Records showed activities were infrequent. For example, one person had an activity recorded on two occasions between March 2020 and November 2020.
• There were no activities planned for when the activity co-ordinator was absent. There were also no activities planned or occurring on the days we visited the service.
• The lack of an allocated budget for activities and entertainment meant these were not a priority. Instead activities which did take place were due to the goodwill of relatives and staff.
• People had not been involved in developing social care plans to help ensure they could participate in activities and follow their interests.

The provider had failed to ensure people were engaged with frequent and meaningful activities. The above is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centred care

Improving care quality in response to complaints or concerns

• The provider did not operate an effective complaints process to ensure people's concerns were fully investigated and sustained improvements made to keep people safe.
• The complaints log was not fully completed which meant it was difficult to identify what action had been taken in response to complaints.

The provider had failed to ensure lessons were learnt from complaints to ensure people remained safe. The above is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• Easy read information was not displayed around the service, for example around complaints or abuse. Information could be made available in various formats, such as easy read and pictorial if requested.

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others
• The provider had not promoted a person-centred or inclusive culture. Staff told us they did not feel supported or appreciated by the provider, especially during the Covid-19 pandemic.
• The proprietors had not provided the necessary investment to promote a safe and nurturing environment in which people could receive good care. There were no dedicated budgets for areas such as refurbishment, activities, management support and staff development.

The provider had failed to ensure people received consistent inclusive and person-centred care. The above is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

• Most staff described the new manager as approachable. Staff told us they were now starting to have one-to-one supervisions. They felt the manager was making improvements and listening to their views.
• The provider worked in partnership with others including the local authority and a range of other professionals.

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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The service lacked robust management to ensure people received quality care and regulatory requirements were met.
• Incidents and complaints identified issues requiring a statutory notification to the CQC, such as allegation of abuse, injury or police involvement. However, these were not always submitted. We are dealing with this matter outside of the inspection process.
• The service did not have a registered manager. A new manager had been employed and was intending to apply to the CQC to become the registered manager.
• The provider lacked a robust and structured system of quality assurance to ensure risks were managed and improvements realised. For example, there was no oversight of health and safety audits which were word-of-mouth and not recorded.
• The provider's quality assurance processes had not been successful in ensuring key aspects of the service were not overlooked. This included ensuring people's needs were met quickly, staff promoted dignity and respect and care record were up-to-date and accurate.

• Systems were inadequate to proactively identify and address risks to people's safety. For example, management had not identified the need for and installed window restrictors to prevent people from falling out of windows. Likewise, air-flow mattress settings had not been checked to keep people's skin intact, resulting in people being placed at risk as mattresses had not been set correctly.

The provider had failed to have robust quality assurance processes in place. This placed people at risk of harm. The above is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care
• The provider was not proactive in ensuring people's and staff member's views were captured and used to improve the service.
• There were very few opportunities for staff to share their views about the service. There had only been two documented staff meetings between January 2020 and November 2020. Staff this was starting to change with the new manager and they were now being listened to.
• The provider failed to use feedback to learn lessons and develop systems to improve people's care and keep them safe.
• Although individual complaints had been investigated, issues raised were still evident when we visited the service. For example, in relation to cleanliness, people's doors being closed and lack of engagement.
• The provider had failed to learn from previous inspections so that improvements to move out of special measures and keep people safe had not been sustained.

The provider had failed to engage with people or act upon previous feedback. This placed people at risk of harm. The above is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

• The provider had developed an action plan to urgently address the immediate concerns and risks identified.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider had failed to ensure at times people received person-centred care in line with their wishes. The provider had failed to ensure people had access to and regularly engaged in activities. The provider had failed to ensure people's care plans were regularly reviewed and updated as people's needs changed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The provider had failed to ensure people were treated with dignity and respect in relation to their clothes and appearance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider had failed to ensure all care plans included people's consent. The provider had failed to ensure capacity assessments had been carried out.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to ensure personal and environmental risks to people were managed

safely. Issues identified during premises safety checks had not been actioned.
The provider had failed to ensure robust infection control procedures were in place.
The provider had failed to ensure safe processes regarding people's medication were in place.
The provider had failed, at times, to refer people to other healthcare professionals in a timely manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to identify poor practice to ensure people were safe from abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to have robust governance processes in place to monitor the overall effectiveness of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure adequate numbers of suitably qualified staff were deployed to support people both safely and emotionally. The provider had failed to ensure staff had completed up-to-date training.