Runwood Homes Limited

Windle Court

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

The last comprehensive inspection of this service was in December 2016 at which time the service received an overall rating of 'Good'. You can read the report from our last inspection on 13 and 15 December 2016 by selecting the 'All reports' link for Windle Court on our website at www.cqc.org.uk.

Windle Court 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 accommodates up to 76 people across three separate units, Jasmine, Poppy and Sunflower. Jasmine unit is a three storey building which is separate from the main building. Poppy unit is situated on the ground floor of the main building and Sunflower unit is situated on the first floor. There were 74 people living at Windle Court when we visited the service on 23 January 2018. When we returned to the service on the 8 February 2018, 71 people were living at Windle Court.

At our inspection we identified a lack of governance, and people were at risk of unnecessary harm. The systems in place to effectively monitor and improve the quality of the service were not robust. The provider had not taken appropriate steps to ensure they had clear scrutiny and oversight of the service which ensured people received safe care and treatment. The lack of managerial oversight had impacted on people, staff and the quality of care provided and had failed to identify and address concerns and breaches of regulatory requirements we found during our inspection.

There had not been a registered manager in post at the service since October 2017. A manager had been recruited who was not yet registered with the Care Quality Commission. 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 legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Improvements were required to ensure sufficient numbers of staff were effectively deployed, so that people's individual care and support needs were met in a timely way.

The standard of record keeping was of a poor standard. Care records were not accurately maintained to ensure staff were provided with clear up to date information which reflected people's current care and support needs. Risks to people had not always been identified. Where risks had been identified people's care records had not always been reviewed and, where appropriate, updated to mitigate these.

People told us they felt safe living at the service, however they were not fully protected from the risk of abuse and harm. Although staff could tell us about the different types of abuse and the actions they would take if they suspected abuse, we found the service had not always raised safeguarding alerts to the safeguarding team.

Although appropriate recruitment procedures were in place to check staffs' suitability to work with vulnerable people before they started work, improvements were required to make sure these were robustly completed for all prospective staff to ensure safer recruitment.

Staff completed the provider's mandatory training but had not received specialist training to equip them with the skills, support and knowledge they needed to provide effective good quality care to people with specific health needs.

Improvements were required to ensure people received their medicines as prescribed, and the service had appropriately trained staff available at all times to administer people's medicines.

Although staff felt supported by the manager, not all staff had received regular supervision. Staff were not always being routinely assessed or checked to ensure they continued to have the right skills and competencies to support people living at the service.

People were not always supported to have maximum choice and control of their lives and staff did not always support people in the least restrictive way as possible.

People were generally positive about the meals provided. There was a choice of food and drinks each day however people did not always receive their preferred food choices. Moreover, documentation used to monitor people's food and fluid intakes were not always being completed, placing people at risk of dehydration and/or poor nutritional intake.

Although people were supported to access healthcare services, improvements were required to ensure appropriate and timely referrals were made to healthcare professionals to support people to maintain their health care needs and well-being.

Whilst staff were kind and caring towards the people they supported and treated people with dignity and respect, they were often task orientated due to staffing numbers and the deployment of staff .

People were supported to maintain relationships with people who were important to them.

At this inspection we found breaches of Regulations 9 [Person centred care], 12 [Safe care and treatment], 13 [Safeguarding service users from abuse and improper treatment], 14 [Meeting nutritional and hydration needs], 17 [Good Governance], 18 [Staffing] and 19 [Fit and proper persons employed] of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also identified a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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?

Inadequate

The service was not safe.

Risks associated with people's health, safety and well-being were not always managed safely.

Improvements are required to ensure sufficient numbers of staff are effectively deployed to meet people's individual care and support needs.

Although there were safeguarding policies and procedures in place, appropriate action had not always been taken following incidents.

Improvements were required to ensure people received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff completed an induction and mandatory training, however they had not received specialist training to enable them to effectively carry out their role.

Improvements were required to support people to maintain good health.

Staff had a basic understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Standards. People's rights and freedoms were not always protected.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff interacted with people in a compassionate and kind way; however staff were often task focussed due to the deployment of staff and trying to manage their workload.

Staff promoted people's independence and treated people with dignity and respect.

Staff provided a caring environment for people who lived at the service and our observations showed that positive relationships had developed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and, where appropriate, their relatives had been involved in the review of their care. However, some care plans contained contradictory information and did not always reflect people's current care and support needs.

Staff did not have time to read care plans.

There was a complaints procedure in place.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager.

Quality assurance systems in place did not effectively monitor and mitigate risks to people's health, safety and welfare

The provider was not meeting regulatory requirements.

Windle Court

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 was planned to check 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 was prompted by information shared with the Care Quality Commission (CQC) on 15 January 2018 by the local authority's safeguarding team and Police with regards to two serious incidents where a person using the service died and another person sustained unexplained bruising on the same day. These incidents are subject to a separate investigation.

The information shared with CQC indicated potential concerns about the management of risk of falls, staff training, staffing numbers, and deployment of staff. We visited the service on the 23 and 24 January 2018 to examine those risks. We needed to be sure that there were no on-going risks to people living at Windle Court. Following the findings of our visit to the service on 23 and 24 January 2018, and additional information subsequently received by the Commission, we completed a full comprehensive inspection of the service on 8 February 2018.

The inspection on the 23 January 2018 was unannounced. The service was aware of our visit on the 24 January 2018. On the 23 January 2018 the inspection team consisted of three inspectors and, on the 24 January 2018, one inspector.

Our inspection on the 8 February 2018 was unannounced. The inspection team consisted of two inspectors, one inspector manager, one specialist nurse adviser, one occupational therapist adviser 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.

Not everyone was able to verbally share with us their experience of life at the service due to living with dementia. We carried out a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We also looked at the environment including communal areas and some people's bedrooms.

During our inspection, we spoke with 27 people living at Windle Court, five relatives and one visitor to gain their views about the service. We also spoke with the home manager, deputy manager, regional operations director, director of marketing and communication and director of operations (England). We spoke with 17 members of care staff and the chef and spent time observing the support staff provided to people.

We looked at a range of records including 12 people's care plans, staff training, nine staff files, rostering information, shift handover logs, arrangements for the management of medication, records of accidents and incidents and quality assurance information.

Inadequate

Is the service safe?

Our findings

At our previous inspection in December 2016 we rated this key question as 'Good'. At this inspection we found this rating had not been sustained and significant improvements were required.

People were at risk because there were not sufficient staffing levels suitably deployed to meet people's individual care and support needs.

Although people told us they felt safe living at Windle Court, people, relatives and visitors repeatedly shared concerns with us about staffing levels and the negative impact that this had on people. One person told us, "I can't fault the staff. They work really hard but there are not enough of them." Another said, "My only complaint is lack of staff. It feels as though they are put upon." Another said, "I can't just say I'd like a bath, there's not enough staff. In an ideal world I'd like more baths. If I'm offered one I say 'yes' as you don't know when the next offer will be." One person told us they did not wish to be a burden on staff and restricted their fluid intake so they would not need to request support from staff with toileting. Another informed us staff had not always been able to respond to their needs in a timely way when they were recently unwell.

Relatives' feedback included, "Staff are thin on the ground. If one of them has to go somewhere or is on a break then [person] has to wait." One relative explained that although they were confident staff knew their loved one well, there were not always enough staff available to meet people's needs. They told us, "One hundred per cent my main concern is the lack of staff."

Staff also told us there were not enough staff to enable them to safely and effectively meet people's care and support needs. One member of staff told us, "We used to have more staff on shift which was much better. We don't know why [management] stopped it." Another staff member told us how they felt the service should be more adaptable with regards to staffing levels. They went on to say, "[The service] should do things that suit not so much the systems but the people." Staff told us they had raised concerns about staffing levels at staff meetings and said the tool used to determine staffing levels was ineffective and did not take into consideration people's fluctuating care needs and the layout of the buildings. They also told us they did not have time to read people's care plans. This meant people were at risk of receiving inappropriate care.

In June 2017, the Commission raised a safeguard alert to the safeguarding team following information received from a whistle blower that there were insufficient numbers of staff working at the service and the impact this had on people, particularly for people living in Jasmine unit. We were assured by the service that a 'floating' member of care staff would be available from the service's other two units to support staff in Jasmine unit when required. We were informed this would ensure adequate staffing levels at all times across all three units and enable people's needs to be met in a timely and safe way.

During our inspection we spent time observing the care and support provided in Jasmine unit. On the first day of our inspection there were two staff members on duty providing care to 14 people. Staff informed us that two people required the assistance of two staff members with moving and handling needs and

personal care. In addition to this, a further four peoples level of needs fluctuated and there were times when they also needed assistance of two staff members. People and relatives told us, and we observed that there were times during the day when one of the staff members had to leave the unit to go across to the main office leaving one member of staff alone on the unit. The home manager informed us that a 'floating' staff member was 'supposed to support staff on the unit during breaks and busy periods. However, this was not always possible because they were busy providing care elsewhere'.

With the exception of two people who preferred to stay in their own rooms, people living in Jasmine spent the day in the communal lounge. We observed one person who was unwell. A healthcare professional had visited the person on the morning of our visit and advised staff to monitor the person's temperature. When the person's relative visited staff discussed their concerns about the person being unwell, including that the person was increasingly sleepy. The relative expressed to us that that they felt their family member would be more comfortable in bed but, due to the lack of staffing, this was difficult and felt this was why their family member had been brought to the communal lounge despite being unwell. We noted in the afternoon the person had been assisted to bed.

During our visit on the 23 January 2018 the fire alarm kept being triggered throughout the day, disabling the passenger lift in Jasmine unit. On one occasion, a person had gone outside and was unable to regain access to go back to their room as the lift had been disabled. Staff were unaware the person was downstairs and had to be alerted to this by an inspector. On another occasion, the floor in the communal lounge was wet. A staff member had left the room to get a mop and bucket to dry the floor, leaving the communal area with no staff presence as the other staff member was busy providing care to a person in their room. A visiting family had to highlight the hazard to people entering the lounge . This lack of staff oversight meant that people were placed at potential risk of falling and injuring themselves.

We discussed our concerns around the effectiveness of the 'floater' system with the home manager and the regional operations director. We asked them how sufficient numbers of staff were determined and deployed to ensure people's needs were met effectively and safely across all three units. They showed us a dependency tool which had been completed a few days prior to our visit. When we reviewed this document we found that 11 people had been omitted from the dependency tool calculation. This meant staffing levels were not reflective of the number of people living at the service. The regional operations director told us that they were in the process of completing a dependency assessment and the deputy manager would be reviewing individuals' care needs the following day to ensure these were calculated correctly. We were assured that the dependency tool would be reviewed on a regular basis and environmental factors such as the layout of the buildings would be considered as part of this exercise.

When we returned to the service on 8 February 2018 we observed one member of staff in Jasmine unit which was compromising the safety of people. We were not assured that the provider had taken appropriate action to ensure sufficient staffing levels. We brought this to the immediate attention of senior management who arranged for the deputy manager to support the unit.

Management informed us that since our visit on the 23 January 2018 an additional night time member of staff had been put in place. They had reviewed people's dependency levels and the outcome showed they had sufficient staffing numbers. We discussed our continued concerns regarding the effectiveness of the dependency tool and were advised day time staffing levels were currently being reviewed. Following out inspection the Regional Operations Director informed us additional staff would be included within the rota for Jasmine unit from 8:00 to 13:00 and 16:00 to 20:00. They confirmed the new rostering arrangements would be reviewed in four weeks' time.

The failure to ensure sufficient numbers of staff were effectively deployed was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had attended training on safeguarding people. Staff we spoke with were confident in the action they would take to report any concerns, both within the organisation and to outside agencies. However, although staff demonstrated an understanding of how to recognise different signs of abuse and report concerns, we found the systems in place to ensure people were safe and protected from avoidable harm, abuse and neglect were not robust.

A safeguarding meeting had been held in July 2017 following safeguarding concerns with regards to staffing, high number of falls and poor manual handling techniques by staff. Following this meeting the safeguarding team and the local authority's quality improvement team supported the service to make improvements. However, at this inspection we could not be assured that lessons had been learned as the systems and procedures in place to ensure people were consistently protected from avoidable harm and abuse were not robust. Accidents and incidents had not always been reported and actioned appropriately. Moreover, safeguarding alerts had not always been made to the local safeguarding authority following incidents such as unwitnessed falls and unexplained bruising.

During our inspection, we found the service had not always responded appropriately to safeguarding concerns for example following falls or injuries. This included not raising safeguarding alerts with the local authority or notifying the Commission of incidents. For example, staff had found one person with unexplained bruising on their hands and arm and swelling to their foot. Although the incident was recorded in the service's accident book, and a '24 hour falls and observation record' had been completed by staff, both these documents had not been signed off by a manager. Moreover, there was no evidence to demonstrate what action had been taken following the incident, and a safeguard alert had not been raised to the local safeguarding authority for further investigation. Another person's care documentation recorded that they had unexplained bruising to their arm and jaw. No body map had been completed until two days following the bruising and care records contained no information about how the bruising had happened. No safeguard alert had been raised by the service and no information regarding the incident was contained in the service's accident book. This meant that people were not always protected from the risk of harm and abuse.

The failure to ensure people were protected from the risk of harm and abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all individual risks to people had been identified and suitable control measures put in place to mitigate these. Furthermore, where risks had been identified people's care records had not always been reviewed and, where appropriate, updated. For example, when people had been discharged from hospital or following visits/recommendations from health care professionals. Although most staff intuitively knew people's care and support needs, care plans and associated risk assessments had not been reviewed to reflect these changes. This meant people were at risk of receiving unsafe care and treatment.

On reviewing care plans, we noted people did not always have care plans and associated risk assessments in place for their specific health conditions such as diabetes or epilepsy. This included clear guidance and key information for staff, such as the actions they should take should a person show signs of an epileptic seizure.

Although the district nursing team supported people with diabetes, we saw there were not always detailed guidance or risk assessments in place to help staff identify when people may be becoming unwell as a result

of their diabetes such as hyperglycaemic or hypoglycaemic episodes. Although staff we spoke with were able to describe the signs of a hyperglycaemic or hypoglycaemic episodes and the actions they would take if they observed this, people were being placed at risk when new or agency staff were working at the service as they would not know people as well as the permanent staff team.

There were no specific care plans for diabetes including risk assessment for foot care. We saw in the care records for one person, a photograph of severely ulcerated feet dated 13 December 2017. There was no evidence to demonstrate these wounds had been identified and appropriate action taken, prior to the 13 December 2017. Nor was there information to evidence the person had received regular foot care or check-ups from a podiatrist since their admission to the service in March 2017. Care records showed the person had three recent admissions to hospital due to poor diabetes management. Their care plan had not been updated to highlight the increased risk of their diabetes and no updated risk management plan was in place. We noted a care plan for insulin was added on 18 January 2018; however, the rest of their care plan records had not been updated to reflect this change such as their eating and drinking care plan. We saw this had subsequently been updated on the 23 January 2018 and continued to state the person was non-insulin dependent.

Good practice guidelines for diabetes management in care homes recommends screening people for diabetes on admission; having a fully stocked hypoglycaemia kit and a risk assessment tool for diabetes foot disease in place and providing good quality diabetes education and training for care staff. We found none of these recommendations were in place.

Care staff told us, and records showed they had not received specialised catheter care training. We saw one person with a catheter in situ. There was no specific care plan in place for this aspect of their care. Although information about catheter care was included in the person's continence care plan, this information was not detailed. There was no guidance for care staff such as to ensure catheters are on stands overnight to prevent infection or information on the symptoms of urinary tract infections (UTIs) and how to recognise when the catheter may be blocked . Although staff were able to identify risks associated with catheters and the signs to look for of infection such as dark urine, blood in urine, low urine output, confusion and pain, there was a risk of people receiving inappropriate care due to the lack of information and guidance in care plans and staff training.

Recommendations from healthcare professionals' were not always followed. We saw in one person's care records guidance from an occupational therapist that the person should wear a palm protector, and have a cushion placed between knees when seated and sleeping to prevent pressure ulcers. We observed the person in a communal lounge. They were not wearing the palm protector and a cushion had not placed between their knees. We spoke with a member of staff who confirmed the person should be wearing palm protector and showed us the equipment which was in their room. This meant the service did not always follow professional advice and guidance to provide safe care and treatment

We looked at how medicines were managed. Senior members of staff were responsible for administering people's medicines and records showed that they had received appropriate training. However, on reviewing staff rotas we found on some occasions during the night shift (22:00 to 07:30) the staff member allocated the senior lead for the shift had not received medication training. This meant there were occasions when no trained staff member was on duty to administer time specific or 'as required' medication such as paracetamol to people.

Staff had completed people's medicine administration records (MARs) correctly and there were no omissions of staff signatures. However, where people were prescribed creams the administration of these

creams was recorded on separate MARs. We found not everyone had a MAR in place for the administration of creams. Where they were in place the MARs had not always been completed by staff, therefore we could not be assured people were receiving their creams as prescribed. During our visit on the 8 February 2018, we saw it had been recorded in one person's daily notes that their skin was sore and required cream to be applied. On the 28 January 2018 the person had 'run out' of their prescribed cream and care staff had reported this to a senior member of staff. There were no further entries evidencing the cream had been applied or information regarding the person's skin condition. We discussed this with a senior member of staff who was able to show us that a fax request for the cream had been made on the 28 January 2018, however this had not been followed up and no-one had identified the person had not had their cream applied.

There were appropriate facilities to store medicines that required specific storage and staff safely administered medicines from lockable trolleys. People's individual MAR included an up to date medication profile detailing their current medication, how they chose to take it and an up to date photograph so that staff could identify people correctly before giving medicines to them. People prescribed medicines to be used 'as required', had clear guidance in place to inform staff of when to use these; medication records showed that staff had adhered to these correctly.

The systems in place to monitor accidents and incidents, including witnessed and unwitnessed falls, had been robustly managed so as to identify trends, determine the cause of falls and take any necessary follow up action. For example, the falls audit for December 2017 identified that 16 people had falls. Some people had more than one fall in the month and/or had fallen in previous months, however the action plan for them stated, 'Current action plan works'. In November 2017 seven out of 16 falls had been in the evening between 22:00 and 07:30. In October 2017 there were 18 recorded falls. The analysis of the data stated there were no timing patterns yet nine falls had occurred at night and 12 falls had been in people's rooms. Where falls had occurred, the service implemented a 24 hours close observation record. These required outcomes to be recorded and for the documentation to be 'signed off' by the manager. We saw that these had not always been completed or signed off. Although staff told us, they would refer people to their GPs if they had repeated falls, we could not be assured that the home manager and provider had clear oversight over the management of falls within the service.

One person's care notes documented they had falls on the 23 September 2017, 14 and 29 December 2017 and 2 February 2018. The person's falls risk assessment documentation made no reference to the accident on 2 February 2018 when they had had been taken to hospital with an injury to their head and with a urinary tract infection. We found the person's care records lacked detail such as environmental risk factors in their bedroom, their reduced mobility and how their cognitive impairment impacted their risk of falls.

People did not always have access to the equipment they required to reduce risks to their health and safety, and maintain their well-being. There had been limited involvement by statutory services such as therapy teams to support the management of falls, and with reviews of equipment, including seating and showering equipment. For example, people with postural concerns were unable to access baths/showers. We also observed two members of staff on the second day of our inspection supporting a person to mobilise using incorrect equipment. We shared our concerns with the provider. They contacted us shortly after our inspection to confirm referrals had been made for people who had recurrent falls, weight loss and to the occupational therapy team for residents with posture and equipment concerns. We were not assured that these referrals would have been made if we had not highlighted these issues to the provider.

The above examples demonstrated a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

People were cared for by staff which the provider had deemed safe to work with them. Although we found appropriate checks had been carried out prior to staff working at the service such as identity checks, employment histories and checks with the Disclosure and Barring Service (DBS), we found recruitment procedures were not always thorough. For example on reviewing four staff recruitment files, we found application forms had not been fully completed and interview notes lacked detail. These files related to care staff with no previous experience of working in the care sector. This meant the provider's recruitment processes had not been robustly adhered to and operated effectively, to check prospective staff's suitability for the role. This placed people at risk of receiving inappropriate care and treatment.

This constituted a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

Measures were in place to ensure people were prevented by the prevention and control of infection. Staff had received appropriate training and infection control audits were carried out. However, we observed several bathroom areas within the service which required deeper cleaning such as under shower/bath chairs. We also found flooring in some bathrooms damaged, therefore presenting a risk of infection. We were informed by the deputy manager the issues we had identified would be immediately addressed. At the time of our inspection the home was subject to an infection outbreak. Management had notified and sought guidance from the Health Protection Unit.

Procedures were in place in the event of an emergency. Staff had received fire safety training and people had Personal Emergency Evacuation Plans (PEEPs) in place which were accessible in the main foyer of the building. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely evacuate a building themselves.

Requires Improvement

Is the service effective?

Our findings

Staff received an induction when they started work at the service, which included completing the provider's mandatory training and shadowing more experienced staff. Although records showed staff received on-going refresher training, they had not received specialised training to enable them to support people with specific health care needs such as diabetes, pressure ulcer management and catheter care. Staff told us they would like this training to enable them to effectively fulfil their role and responsibilities. The failure by the provider to ensure staff received relevant specialist training meant staff may not have the knowledge and skills to meet people's needs effectively and safely thereby placing people at risk of receiving inappropriate care and treatment.

Staff told us, and records showed they received regular supervision. However, this was not consistent for all staff. Four night staff files we reviewed showed the staff had received minimal supervision; one staff member who started work at the service in April 2017 had received no supervision. We also found no evidence to show follow up action had been taken by management for two staff regarding concerns over their care practices. Supervision is important as it enables staff to discuss work related matters including their training and development. During our inspection, the home manager showed us a supervision planner they had developed to ensure staff received regular supervision in line with the provider's policy.

These findings demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people had been identified as being at risk of not eating or drinking enough. Although food and fluid intake charts were in place these had not always been fully completed, including the setting of daily fluid intake targets for individuals, to show their daily fluid intake had been sufficient. A member of staff told us they had not received any training on how to use the fluid balance charts or the rationale for using them. Although we observed people being offered drinks and biscuits during our inspection we could not be assured that the service was effectively managing the nutritional and hydration needs of people who were at risk.

Where people had lost weight it was not always clearly recorded in their care plans what actions had been taken, such as a referral to the speech and language team (SALT). One person had lost 15.2kg between the period 1 November 2017 to 26 January 2018. The person's care plan stated they had lost weight due to loss of fluid following cellulitis. The care plan had also stated the person ate small amounts. When we spoke with the person about what they liked to eat, they informed us they liked trifle. There was no mention of this in their care plan. We also noted nutritional and fluid intake logs for the 7 and 8 February 2018 recorded the person had minimal intake. We discussed the person's nutritional intake with a member of staff. They informed us the person's intake 'was fine and supplements were not required'. We found no evidence to demonstrate how the service had been proactive in making appropriate referrals to support the person's dietary needs and investigate their significant weight loss.

We observed the lunchtime experience for people in two of the service's lounges. The lunch was a pleasant,

social occasion. Staff took time to provide high levels of choice and engaged in lively conversations with people. We received mixed feedback about the food available. One person told us, "There's a good choice and they will do something else if I ask. I'm never hungry. We are always being offered drinks too, I don't get thirsty." Another person told us they 'did not rate the food'. They went on to say, "For example the mashed potato is Smash its horrible, no taste. And the corn beef hash was burnt on the bottom and hardly done on top. Three peach slices and cream is not a dessert especially on a cold day like today, what about a hot sponge and custard, or crumble or pie?" One person told us they preferred a vegetarian diet but there were limited vegetarian menu options. They said, "Occasionally they do a baked potato so I'll have that but they don't do a vegetarian option." They showed us a drawer in their room containing packets of rice meals. They told us they requested staff to heat these up for them each day. We noted the meal options available on the day of our visit were corned beef hash or lamb casserole. We discussed our findings with senior management who assured us vegetarian options were available if required.

Kitchen staff held information on people's dietary requirements including any food allergies. However, we noted where people preferred vegetarian meals, this information had not been recorded.

The above examples demonstrated a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty safeguards (DoLS). The 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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff had received MCA and DoLS training and understood the basic principles of the MCA and the importance of consent. They explained to us how they gained people's consent to their care and helped people to make choices on a day to day basis. Generally, we found good practice with regards to how the service assessed, and recorded, people's capacity to make decisions. However we saw an assessment for one person where it had been recorded they had capacity to make a particular decision, yet a 'best interest' decision had been made. Best interest decisions should only be made if a person lacks capacity. This demonstrated a lack of understanding about the legislation and meant people's rights and freedoms were not well protected.

During our inspection, we observed staff administering covert medication. There was a letter of approval from the person's GP but no advice had been sourced from a pharmacist to ensure it was in the person's 'best interest' to have their medication administered in this way. We identified this as an area requiring improvement at our last inspection. It is best practice to consult a pharmacist to ensure that the properties of the medication being administered covertly remain effective once mixed with food or drink and ingested; and to confirm the decision to administer medicines covertly was in the individual's 'best interests'. Where people had been deprived of their liberty appropriate applications had been made to the local authority for a DoLS authorisation.

We recommend the registered provider reviews this legislation and associated guidance to ensure they are

acting in accordance with the MCA.

People were generally supported to access healthcare services and professionals such as GPs, occupational therapists and the community nursing team. One person told us, "Staff would pick up if I was unwell, that gives you confidence that I'm in the best place." A relative said, "Staff contact me if anything happens to [person]." The outcome of appointments including recommendations from healthcare professionals was recorded in people's care plans however this was not always consistent and people's care plans were not always updated. We found there were sometimes gaps in recording following visits from healthcare professionals. This made it difficult to establish whether people had received effective care and support. For example, a visit from an occupational therapist had advised staff not to use a new chair for a person until an engineer had completed adjustments to it. We observed the person sitting in their new chair. Staff told us the engineer had been back to the service to carry out the necessary adjustments, but this had not been recorded. We also saw advice and recommendations from healthcare professionals was not always followed; examples of this can be found in the Safe section of this report.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in December 2016 we rated this key question as 'Good'. At this inspection we found this rating had not been sustained and improvements were required.

People and their relatives told us staff were caring and kind. One person said, "I couldn't wish for better girls here. They're very caring, they're here to help and they would do anything for us." They went on to say, "They are very friendly people, it's all very personalised here." Another said, "The carers are perfect they treat you like royalty, they really do." A relative told us, "They're marvellous, they are kindness in itself."

Although, we observed staff interacting with people in a compassionate and kind way, they were often task focussed due to the deployment of staff and trying to manage their workload. One person told us, "[Staff] say they would like to stop and chat with us more but they don't have time." Staff provided a caring environment for people who lived at the service and our observations showed that positive relationships had developed. It was clearly evident people valued their relationships with the staff. Although staff were caring, the provider did not have a caring approach because they did not ensure staff had the time and information they required to provide person centred care and support.

Care plans contained information on people's life histories to help staff know about the person. We observed bedroom doors displayed a short account of people's lives or interests which helped staff and visitors to engage with the person. However, although staff were knowledgeable about the people living at the service, they told us they did not have time to read people's care plans. This meant staff, including new and agency staff, may not have important information to enable them to know about the people they were supporting.

We asked people whether they knew about their care plan and whether they had been involved in the review of their care needs. One person told us, "I know they write in there about my health needs and keep records of tablets etc. Other than that I don't know." They went on to say, "They did ask me things about my life and family but I'm not sure staff would have the time to read that." Another person told us, "I go to bed at 12pm, nobody persuades me to go earlier." They added they used to have a dedicated keyworker and they missed not having one. When we spoke with other people, they also did not know whether the keyworker system remained in place. We discussed this with senior management who advised they were currently reviewing the keyworker system.

People received an annual review of their care plan and relatives, where appropriate, had been invited to participate. One relative told us, "I still feel involved in [person's] care. They will talk with me first if there's a plan to change tablets or anything else to do with their health."

Care plans showed people's strengths and abilities had been identified to promote their independence. For example one person's care plan stated, '[Person] can brush their own teeth, just needs help with toothpaste' . However, we could not be assured all care staff, particularly new and agency staff, were aware of this information as staff told us they did not have time to read people's care plans. Staff were able to describe to

us how they supported people to maintain their independence. One member of staff told us, "[Person] is very independent so I will just lay their clothes out and they can get dressed by themselves. We will always offer help but let people choose if they want to accept it."

People told us they were treated with respect and staff were able to provide examples of how people's privacy and dignity was respected. One person told us, "The staff are good, they treat me respectfully and knock on my door." Dignity was promoted within the service. We saw a 'Dignity Tree' displayed with quotations from people and staff on what dignity means to them. This included, 'Dignity is to be able to ask for help when needed', 'Dignity is behaving in a respectful way to me and calling me by my name'; and 'Dignity is treating a person as the individual they truly are.'

People were supported to maintain relationships with friends and families. There were several areas within the service where people could receive their visitors including a 'garden café' which offered a private space. People told us their families were made to feel welcome when they visited. One person said, "My girls come regularly, they always feel at home here, I'm pleased about that." A relative said, "It's nice to be able to have a cup of tea with [person] when I visit, it feels almost like old times."

The service had information on advocacy services. An advocate supports a person to have an independent voice and enables them to express their views when they are unable to do so for themselves. At the time of our inspection one person was being supported to access an advocate.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in December 2016 we rated this key question as 'Good'. At this inspection we found this rating had not been sustained and improvements were required.

Prior to coming to live at Windle Court, a holistic assessment of people's care and support needs had been completed to ensure these could be met by the service. The information from the assessment was used to develop people's care plans. People's care plans covered a range of areas such as mobility, nutritional, medical and personal care needs. A section of the care plan was called 'My Day'. This provided staff with a pen portrait of people's preferred routines to support person centred care. Staff we spoke with were able to demonstrate they knew people well and were able to accurately describe people's likes, dislikes and routines. For example, staff knew which people liked tea or coffee, whether they liked sugar in their drink and what time they liked to go to bed. The information staff provided us matched with what was recorded in people's care plans. However, as highlighted in the Safe and Caring sections of this report, staff repeatedly told us they did not have time to read people's care plans, so there was a risk new and agency staff would not know this information.

Care plans were not always reflective of people's care and support needs and were not always updated following a change to people's needs. For example, people had their falls assessments reviewed on a monthly basis however, their care plans had not always been updated and reviewed following falls. One person had sustained several falls in 2017 resulting in a hip fracture and hospitalisation. Their care plan and risk assessment had not been updated. This meant there was limited guidance in place to mitigate the risks of further falls. We also noted contradictory information in people's care plans. For example, in one person's care plan who was cared for in bed, it stated the person could weight bare and in other sections of their care plan, it stated they were unable to weight bare. Without the correct information a person may be placed at risk of being moved unsafely and result in injury.

People's medical history had not always been well documented. One person's medical history had not recorded information regarding their cognitive issues. Throughout their care plan their cognition was described as 'confused'. A CT (computed tomography) scan dated 2 February 2018 showed evidence of cognitive problems, however this had not been transferred to the care plan documentation to show the person had reduced safety awareness and the impact this had on the overall management of their care.

During our inspection, one person was receiving end of life care. There was no end of life care plan in place for the person. There was also no documentation in place to demonstrate how the service was working in partnership with other professionals. We saw the person had been prescribed PRN (as and when required) medication for pain relief. On checking their medication administration record we saw this had been consistently refused by the person. We could see no evidence to demonstrate that the service had explored the reasons as to why the person had refused their medication. No other pain management plan was in place to alleviate the person's pain and meet their care needs.

The above examples demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

A weekly activities programme was displayed in various areas of the service and in some people's bedrooms. Most people we spoke with told us the weekly activities timetable was rarely kept to. Several people said this was due to lack of staff. One person told us, "Today [morning] for example 'jigsaws and puzzles' with carers. Not happened, as there are not enough carers. And this afternoon chatting and reminiscing' with carers. Guess what, not enough carers, it's not happened." They went on to inform us that out of a weekly programme detailing 14 separate activities probably only two happened on a regular basis. Another person told us, "There's not enough things going on here. It's down to the lack of staff, it's not their fault." They went on to say, "We get a weekly activities rota but I don't know why because things often don't happen at all." The lack of meaningful activities has been shown to affect the mental and physical well-being of people living in care homes and can result in people becoming increasingly dependent and infirm, as well as resulting in low mood and poor motivation.

However, whilst we did not observe any organised activities during our inspection, we were informed that the activities co-ordinator was on leave. We did observe one person being supported to play the piano in one of the communal lounges. Other people were in the lounge and were enjoying the music. When a member of staff requested a particular song to be played, we saw people joining in and singing along.

Where appropriate, Do Not Attempt Resuscitations (DNARs) were in place and had been discussed with the person and/or their representatives. Although we noted people's end of life wishes had been discussed and documented this was not always consistent. We recommend that the service regularly reviews and records people's end of life wishes to ensure people receive dignified and comfortable end of life care.

The provider had a complaints policy in place for receiving and dealing with complaints. The service had received 12 complaints since our last inspection. These had been dealt with in line with the provider's policy.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in December 2016 we rated this key question as 'Good'. At this inspection we found this rating had not been sustained and significant improvements were required.

The service did not have a registered manager. The home manager had been in post overseeing the day to day management of the service since October 2017, and was in the process of registering with the Commission.

Improvements were required to ensure all the provider's quality assurance systems were being used effectively to drive improvements and to ensure high quality care was consistently delivered. It was apparent from our inspection that the lack of robust quality monitoring and auditing was a contributory factor to the failure of the provider to recognise breaches or any risk of breaches with regulatory requirements. At the time of our inspection the local authority had placed a suspension on admissions to the service due to concerns.

The systems in place to learn from accidents and incidents were not always effective as these had not been thoroughly analysed to identify trends or concerns, and enabling appropriate measures to be put in place to mitigate reoccurrence This included robust examination of witnessed and unwitnessed falls, safeguarding incidents and staffing levels. Moreover, not all incidents had been reported to the safeguarding authority for further investigation so as to ensure people were protected from the risk of harm and abuse; for example following unwitnessed falls and people sustaining unexplained bruising.

Improvements were required to improve the standard of record keeping. During our inspection, the home manager was unable to provide us with requested documentation such as shift handover logs and night observation charts. In addition, accurate and contemporaneous care records were not consistently kept and care plans were not always reflective of people's current care and support needs. For example, care plans and associated risk assessments had not been reviewed and updated following changes in people's needs or following advice and guidance from healthcare professionals. Staff had also not maintained accurate records in regards to healthcare interventions, fluid and nutritional intakes, observational checks, and daily communication notes.
Moreover, staff, including new and agency staff, may not be aware of people's specific care and support needs, thereby placing people at risk of not receiving safe, appropriate care from staff.

Medication management and monitoring had also not identified the issues we found with regards to omissions in topical cream charts and ensuring pain management plans were in place where required.

The above failings demonstrated a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had not always submitted statutory notifications to the Care Quality Commission (CQC) as required. Statutory notifications are information about specific important events the service is legally

obliged to send to us. It also helps the provider to demonstrate they have taken effective action when people have been injured or involved in incidences that have caused them harm. We look to see if the provider had systems in place to identify and mitigate known risks and how they keep people using the service, staff, and visitors informed about how they are learning and limiting reoccurrence. This also involves a 'duty of candour' when investigating such matters.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There had been a number of management changes at the service which had impacted on staff. Staff told us at times it was difficult to keep up with the changes and expectations of each new manager. One staff member told us, "[Staff] have felt the burden of the changes in management. Not all have been supportive." Staff told us the new manager was approachable and had been 'hands on' when required and operated an open door policy. They also told us that the manager contacted the service and spoke with staff on every unit when they were not on site to check everything was alright. A relative told us, "There have been so many managers over the years, it's not been good." They went on to say, "I think [manager's name] does their best but the higher management of the company don't help them."

The home manager had received no formal supervision since their appointment in October 2017. The regional area director explained that they were still in the process of going through the manager's induction programme. Despite the lack of formal supervision, the home manager told us they felt supported by the regional area director who had taken over as their line manager in December 2017. The home manager was supported two days a week by a registered manager from one of the other provider's services. A deputy manager had started work at the service on the first day of our inspection. The manager told us the support of the deputy manager would be invaluable in supporting them to drive improvements.

Resident and relatives meetings had taken place since our last inspection. This showed us that there were opportunities to seek the views of people using the service and others, enabling them to be involved in making decisions about the day to day running of the service. However, we received mixed feedback about these meetings. One person told us they enjoyed having the opportunity to share their views. They said, "We could tell them a lot more if they wanted to ask us like you're doing." Another person told us, "We have residents meetings about once a month, also relatives do too. Things don't always change as a result though, that's a bit disappointing." A relative said, "I've only been to one relatives meeting. I just found it very depressing so I haven't been again. [Meetings] are also not held at a convenient time for me."

Following our inspection, due to the high levels of risks we found at our inspection we wrote an urgent letter to the provider requesting what action they would be taking to immediately address the issues we had identified. In response to our letter, the registered provider forwarded to the Commission a comprehensive action plan detailing how they would be ensuring regulatory requirements were met. We will continue to monitor the progress by the registered provider in meeting this action plan.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not always submitted statutory notifications to the Care Quality Commission as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not always reflective of people's current care and support needs. Some care plans lacked clear guidance and information to enable staff to support people safely and effectively. This meant people were at risk of receiving unsafe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and safety were not always accurately assessed, recorded and monitored. The provider did not do all that was reasonably practicable to mitigate risks and prevent people from receiving unsafe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not always reported

safeguarding incidents to the safeguarding authority for further investigation so as to ensure people were protected from the risk of harm and abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The systems and processes in place to effectively ensure people received adequate nutrition and hydration were ineffective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems and processes in place that operated effectively to assess, monitor and improve the quality of the service and ensure compliance with regulatory requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider's recruitment procedures had not always been followed to check prospective staff's suitability for the role they had applied for.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed at the service to ensure the care and support needs of people could be safely met.