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Four Winds Residential Home

Inspection report

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Date of inspection visit: 3 and 5 February 2015
Date of publication: 31/03/2015

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?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 3 and 5 February 2015. This was an unannounced inspection. This means the provider did not know we would be visiting. We last inspected Four Winds Residential Home on 12 June 2014 where we found the provider to be meeting all the standards we inspected.

Four Winds is a residential care home registered to provide care for up to 26 people some of whom were living with dementia. At the time of the inspection 22 people were living at Four Winds Residential Home.

Two registered managers were in post at the time of the inspection and had been registered since June 2014. 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.

We found the provider had breached Regulations 9, 10, 13, 18 and 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

People were not protected against the risks of receiving care that was inappropriate or unsafe. There was no effective system in place to regularly asses and monitor the quality of the services provided. The identification, assessment and management of risks in relation to the health, welfare and safety of people was not being managed appropriately. Senior care staff were completing some audits of records, including care plans but these were not effective in identifying area's for improvement and action needed to maintain a high quality of service provision. We saw no evidence of registered managers quality assurance systems or oversight of senior care audits. One registered manager told us that they did not complete audits or improvement plans.

People's individual needs had not been robustly assessed and care plans and risk assessments were not appropriate to meet people's needs. Care plans had been evaluated on a monthly basis but any changes to level of need or circumstance had not led to a new care plan being developed. We saw that some care plans contained contradictory and confusing information.

Risk assessments for the use of specialised equipment such as walking aids and wheelchairs were not always in place. This meant people were not receiving care that met their needs.

We saw that medicines were stored safely and in a temperature controlled environment. However people were not protected from the risks of unsafe administration and recording. We saw that medicines were signed as having been administered before they were given to people. We also saw gaps in recording on Medicine Administration Records. There were no audit systems in place to monitor medicines management.

The registered managers' understanding of The Mental Capacity Act 2005 (MCA) was limited in terms of supporting people to make day to day decisions with regard to capacity to consent to care. The registered managers explained that they would not complete any capacity assessments and best interest decisions without the involvement of a best interest assessor and a doctor if they felt the person lacked capacity. The mental capacity act code of practice is clear that for day to day decisions such as bathing it would be the people closest to the person, for example care staff, who would be best placed to support with this decision making.

Staff told us they received an annual appraisal but records showed gaps. Not all staff had received an annual appraisal. We reviewed training records and saw gaps in the delivery and attendance of refresher training for safeguarding, mental capacity, moving and handling and medicines. This meant people were at risk of receiving care from staff who did not have the skills and knowledge to consistently meet their needs.

Accidents and incidents were recorded however there was no analysis of these incidents which meant people who had regular falls had not been referred to the falls clinic or other appropriate professionals for assessment. There was no effective means to identify areas for improvement or lessons learnt.

An emergency plan was in place and had been signed as reviewed on an annual basis. However it had not been kept up to date as staffing levels did not reflect the current situation. Therefore people were at risk as the emergency plan may not have been effective with reduced staff.

We saw staff had positive and caring relationships with people but noted that people's dignity and respect was not always maintained to a high standard.

The registered managers understood the process for Deprivation of Liberty Safeguards (DoLS) and we saw that authorisations were in place.

People confirmed there were enough staff employed at Four Winds Residential Home and we saw that a dependency tool was used to identify people's needs and the staffing levels required. We noted that the hours provided were often in excess of the hours identified as needed on the staffing tool.

Staff told us they felt supported by the registered manager and they had an open door policy. Staff explained they received supervision which was completed by either the senior care staff or the registered managers.

Appropriate recruitment practices were in place.

Staff had a good understanding of safeguarding and told us they felt confident to report any concerns.

The home had good links with the infection and prevention nurse and staff attended an annual

Summary of findings

programme of training with the nurse. The nurse confirmed that the home had an infection control champion who attended study days and acted as a liaison between the nurse and the care staff at the home.

Staff had some knowledge about challenging behaviour and used distraction techniques to support people who were anxious however it was noted that no training had been provided in the management of challenging behaviour.

There were mixed comments about the food. Some people told us the food was “alright.” Others had complained that it was often cold and had raised this during residents meetings. We saw that mealtimes were sociable events and people were supported as needed.

The home employed an activities coordinator who engaged many of the people with activities such as chair exercises, bingo, cooking and knitting. People told us they thought the activities were good and the coordinator had ideas for improving things further.

Complaints were recorded but there was no effective system in place for analysing trends and developing improvements across the home.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Risks had not been robustly assessed so people were at risk of receiving care that did not ensure their individual needs were met.

There was no robust system in place for the accurate recording, administration and management of medicines which meant people were not protected from the unsafe use of medicines.

Staff were knowledgeable about safeguarding procedures and actions to take to report concerns.

Is the service effective?

Requires Improvement

The service was not always effective. We found gaps in the provision of training which meant people were at risk of unsafe working practice from staff who did not have the skills and knowledge to consistently meet their needs.

Deprivation of Liberty Safeguard authorisations were in place but we found the Mental Capacity Act (2005) code of practice was not understood so people were at risk of having their right to be supported to make decisions themselves denied them.

People told us the food was alright but two people told us they had complained that it was cold.

Is the service caring?

Requires Improvement

The service was not always caring. Staff treated people kindly but we found that people were not always supported to maintain their dignity and privacy.

People said they liked the staff and we observed staff spending time engaging with people in a warm way.

People did not have access to advocacy although the registered manager said they planned to speak to people about advocacy support.

Is the service responsive?

Inadequate

The service was not responsive. We saw no evidence of person centred

care which meant care plans and risk assessments had not been planned to meet individual need.

Care plans and risk assessments were not reviewed in line with people's changing needs. This meant people's welfare and safety was at risk.

An activities coordinator was in post and we saw people were engaged in activities. One person told us the activities coordinator was good.

Complaints from people living at Four Winds Residential Home were recorded but there was no evidence of robust analysis and lessons learnt.

Summary of findings

Is the service well-led?

Inadequate

The service was not well-led. The service did not have robust systems in place to ensure it was being well-led.

Quality assurance systems and audit processes did not ensure the service operated safely or effectively. There was no registered manager oversight of the systems that were in place.

Statutory notifications that providers are legally obliged to complete were not always being submitted.

Four Winds Residential Home

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.

The inspection took place on 3 and 5 February 2015. Both days of inspection were unannounced, this meant the provider did not know we would be visiting. The inspection team included two adult social care inspectors.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

During the inspection we spoke with five people who lived at Four Winds Residential home. We did not speak to any visitors or relatives as there was an outbreak of diarrhoea and vomiting at the time of the inspection. The registered managers advised that relatives were probably not visiting due to the outbreak. We spoke with six staff, including care staff, ancillary staff, the activities coordinator and the admin manager. We also spoke with the two registered managers. Ancillary staff are staff who worked in the kitchen or who provided domestic and hygiene support. We contacted the local authority commissioners and the infection control lead during the inspection.

We used a Short Observation Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

We looked at six people's care records and eight people's medicines records. We reviewed six staff files including recruitment processes. We reviewed the supervision and training reports as well as records relating to the management of the service. The registered manager was invited to forward us up to date training and supervision and appraisal log after the inspection but these were not received.

We looked around the building and spent time in the communal areas.

Inadequate

Is the service safe?

Our findings

An accident and incident recording system was in place. Incidents of people falling were recorded but these were not acted upon appropriately. We reviewed nineteen recorded falls by name, incident and date. The actions taken following these falls included observing people. We reviewed care records of people who had been recorded as having regular falls and we saw no evidence in the action taken or in people's care records of appropriate professionals being contacted. We spoke with the manager who told us they, "Had not contacted the Falls Team or analysed any of the incidents." This meant people were at risk of not being appropriately assessed. This also meant people may not receive the care or support they need to keep them them safe and prevent future accidents.

The providers approach to risk management was not effective or robust. Care plans included two to three lines in relation to risk management. They generally advised staff that the care plan should be followed in order to reduce risk. There were no specific strategies or control measures identified or recorded to evidence that risks were being managed safely and effectively.

One person told us they used a wheelchair while living at Four Winds. They explained the staff from the home had given them the wheelchair to use. We saw no evidence of any referrals to the appropriate professionals for this person to be assessed for a walking aid or wheelchair. We spoke with the registered manager who confirmed they had not contacted the Falls Team. This meant the wheelchair may not be appropriate to meet the person's needs so they be at risk of poor posture and reduced mobility through lack of professional assessment.

We found risks had not been robustly assessed or managed to meet people's individual needs.

The business continuity file contained documents titled 'Resident Risk Assessment' which recorded information on people's mobility and level of understanding. The risk level had been added to the bottom of each sheet. However, we saw no evidence of how this had been calculated, what the likelihood of the risk was or the impact of the risk. We found these had been reviewed but the record of the review did not provide a meaningful update of the outcome of the review. For example, the reverse of the page detailed monthly reviews which stated 'no changes.' This meant it was not possible to confirm whether the risk assessment was still relevant to the person's needs.

An emergency plan was in place which stated that staffing levels should be five or six staff during the morning, three staff during the afternoon and two staff at night. The plan also covered contingencies for severe weather, heating failure and staff disruption. This plan was written in February 2012. It was evident from the rota and the registered manager's comments that changes had been made to staffing levels since the emergency plan had been written. These changes had not been made to the plan even though it had been signed as reviewed in both February 2013 and February 2014. This meant the plan was not up to date as it did not reflect the current situation with regards to staffing levels.

People were at risk of receiving care that did not ensure their safety or welfare. We asked the registered manager if they supported any people with their personal finances. They explained that they provided support for one person to go to the bank and for another person to do shopping for personal items. We asked to view the risk assessments for financial transaction and were told, "No, no this hasn't been risk assessed."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed a medicine round. We saw people were mentioned by name and asked if they were ready for their tablets. Staff checked the MAR against the medicines but signed to record that medicines had been administered before they had been given. When asked about this the senior staff member said, "Oh yes, if someone refuses then I just write it underneath and put comments on the reverse." We saw no evidence of any comments on the reverse of the MAR. When asked about it the registered manager said, "I've told them about it before; I've told them to use the dot and pot system and then sign." This meant staff were not following the registered manger's guidance around agreed medicines procedures placing people at an increased risk of medicines errors.

Records did not support the safe administration of medicines. We checked people's MARs and saw gaps in recording for seven out of eight people. For example, one person's medicine administration record showed that a

Is the service safe?

particular medicine had not been signed for between 12 January and 2 February 2015. There was no coding system used to indicate why there was no record of this medicine having been given and no notes on the reverse of the MAR to explain the gaps in recording.

We looked at how the registered managers monitored and checked medicines management to make sure they were being handled properly and safely. We found no evidence that the registered managers were completing medicines audits to identify and investigate issues relating to medicines or to assess the quality of recording of medicines records. The registered manager told us they were unaware of the gaps in people's medicine records.

We saw one person's medicines care plan was dated 28 March 2012 and stated, 'follow MAR, a trained senior to administer and to hold an annual review with the GP'. This format was used for all medicines care plans viewed. We saw no information regarding why the person had been prescribed the medicine. This meant staff did not have access to information about the person's needs and would be unable to explain to the person what medicine they were taking and why.

We reviewed another person's medicines care plan dated 5 March 2012. This stated that the person had requested staff administer medicines as they felt they may forget to take it or may take the wrong medicines at the wrong time. The risk assessment dated 22 April 2014 stated for staff to leave prescribed medicines on the bedside table until the person retired to bed. It was recorded in the person's records that they had 'assured seniors that they were capable of remembering to take the medicine before they went to sleep.' This information was contradictory and puts the person at risk of receiving inappropriate care and missing medicines.

Some people had been prescribed medicines to be administered 'as and when required.' We saw no evidence of care plans or protocols for staff to refer to. This meant there was a risk that care staff did not have enough information about what the medicines were prescribed for and how to safely administer them.

We found that people were not protected from the unsafe use and management of medicines as there was no robust system in place for the accurate recording, administration and management of medicines.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When asked about the times of medicine administration. One of the registered managers told us, "We don't have a specific time for medicines as long as there are four hours in between. One person has time specific medicine once a week on a Sunday, one hour before breakfast." We saw this was recorded on the medicine administration record (MAR).

People's medicines were stored securely. Records were kept of room and fridge temperatures to ensure medicines were stored at the correct temperature.

When asked about staffing levels the registered manager told us, "Care hours are used to determine staffing levels." They said, "We have one senior and three care staff on the morning and late shift and one senior care staff member and one care staff at night." We reviewed rotas and found that these staffing levels had been met. The registered manager told us, "We can use staff from a sister home if we are ever short staffed." We saw that a dependency tool was in use to calculate staffing hours and it was recorded that the hours on the rota were in excess of the hours calculated using the dependency tool.

One person told us, "Enough staff work here, all the men have left but I'm used to the lasses."

Care staff confirmed that there were enough staff and explained there was always one senior on shift, they added "all staff do a mixture of shifts, mornings, lates and nights."

People told us they were well cared for and felt safe with the staff who provided their care and support. One person told us, "I am happy living here. Staff are nice and helpful."

When asked about the recruitment process the registered manger told us, "We advertise in the job centre, arrange interviews, complete application forms and we observe interactions with people, interview and then make a decision. We wait for the Disclosure and Barring Service Check (DBS) and references before starting people." DBS is a check to ensure people are suitable to work with vulnerable adults or children. The registered manager added, "We are going to ask residents if they want to join the interview panel." We saw that appropriate checks had been completed before staff started employment.

Staff we spoke with were confident they would know how to recognise abuse and would report it accordingly. Staff we spoke with were able to tell us how they would respond

Inadequate

Is the service safe?

to any allegations, or incidents of abuse and were aware of the lines of reporting within the organisation. One staff member told us, "I believe the manager would act on any concerns I would have." A senior care staff member explained that they understood what safeguarding meant. They said, "I could put safeguarding's through, I know the process and the managers always on the end of the phone for advice if it's needed."

A safeguarding log was in place. The provider had reported safeguarding concerns to the local authority as required. However, the log did not show any evidence of investigation's completed or action taken in response to these allegations. Both these incidents had been notified to CQC as required.

At the time of the inspection there was a diarrhoea and vomiting outbreak at the home. There was a notice on the entrance to the home advising people of this and the registered manager told us all relatives had been informed.

The registered manager was asked if people had been seen by a GP. They told us, "A GP visits once a week as part of an umbrella service." One person told us, "Lots of people are poorly here."

During the inspection Public Health England rang for an update on the outbreak and we observed the senior care staff member advising a social worker that they were unable to admit anyone into the home due to the outbreak.

On day two of the inspection the number of people affected by the outbreak had increased so barrier nursing had been put into place and all relevant people such as families and public health had been informed. The registered manager told us, "We have an infection control plan in place and pathways to follow as directed by the infection control nurse."

The infection control nurse told us that she was aware of the outbreak and that the home was closed to admissions due to the outbreak. They told us that the home has been very pro-active in managing infections and outbreaks. They confirmed that they delivered annual training in infection prevention and control for the staff at the home and an infection control champion always attended the two study days for champions and fed back to staff at the home. A self-assessed infection control audit had been submitted by the home in January 2015 and their score was 99%.

Requires Improvement

Is the service effective?

Our findings

A senior care staff member told us, “Appraisals are done by the managers, we feed into them though.” We reviewed staff records and noticed that five out of six staff we checked had not received an annual appraisal within the last year. The manager confirmed not all staff had received a recent annual appraisal. Appraisals provide a formal way for staff and their line manager to talk about performance issues, raise concerns, or ask for additional training.

We reviewed the staff training matrix and noted that there were a significant number of staff needing to attend training to enable them to provide safe care for people.

The training matrix documented refresher periods for safeguarding adults training and moving and handling training as annual. One registered manager had last completed safeguarding training in January 2011, the other registered manager completed it in November 2012.This meant training for both the registered managers was out of date. 15 out of 21 care staff had safeguarding training that was current and met the providers standard for annual refresher training. 16 out of 21 care staff had not received annual moving and handling training and only one registered mangers training was in date. The other registered manager had not completed moving and handling training since April 2009. The registered manager and the administration manager told us they were waiting for confirmation of training from the local authority. They said the available dates “were poor.” This was specifically for safeguarding and moving and handling training.

We looked at medicines awareness training and found that two seniors and one registered manager had training that was in date. One registered manager had not completed medicines training since August 2011 and one senior had last attended training in May 2011. The recorded refresher period was three years so one registered manager and one senior had training that was out of date.

We looked at mental capacity act training records. We saw that 16 out of 21 care staff had not completed up to date training. Neither registered manager had training that was in line with the organisations refresher periods of one year The registered managers had last completed training in June 2011 and November 2012.

The training record showed no evidence of any staff having received training in dementia care or challenging behaviour.

We saw that new staff completed an induction pack which included competency based questions around whistleblowing, moving and handling, fire safety, and care plans. Observations had been completed on the bath hoist, wheelchair use, the manual hoist and the hoover. This had been signed off but there was no record of what had been assessed or observed.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff were aware of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and five authorisations to deprive people of their liberty were in place. CQC had been notified of the authorisations.

When asked how people were supported to make day to day decisions when they did not have capacity one of the registered managers said, “A doctor comes out to do a DoLS interview with staff, the person and their family and they make the decision whether it needs to go to DoLS authorisation. A best interest assessor would also attend.” When asked again about day to day decisions they said, “The doctor would put a referral through to mental health and they would visit to speak with the resident or appoint an IMCA. This is standard procedure.” An IMCA is an Independent Mental Capacity Advocate who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no one else to support them.

This shows limited understanding of consent and MCA (2005). The code of practice for MCA (2005) clearly states ‘The person who assesses an individual’s capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made. This means that different people will be involved in assessing someone’s capacity to make different decisions at different times.’ It goes on to state, ‘For most day to day decisions, this will be the person caring for them at the time a decision must be made. For example, a care worker might need to assess if a person can agree to being bathed and a district nurse might assess if a person can consent to having a dressing changed.’ This means care

Requires Improvement

Is the service effective?

staff would be supporting people on a day to day basis to make decisions in their 'best interest'. The strategy for supporting people should be documented in people's care records.

When asked if staff completed any capacity assessments as an initial process. They said, "We don't do any MCA act assessments for capacity. We would always ask for help from the professional bodies." They added, "We might refer to ICLES the Intensive, Community Liaison Team and complete behaviour charts and check for infections to ensure it wasn't an infection related issue. Then the mental health team decides whether the resident lacks capacity to make decisions."

We asked a senior care member about obtaining peoples consent and they said, "I share my opinion in MCA assessments and decision making – there's input from everyone." They went on to say, "There are a few people on DoLs, it's updated regularly."

We did not see any evidence in care records of how people with the capacity to make decisions were involved in consenting to the care they received.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they were happy with the staff delivering their care. One person commented, "The staff do their best."

Staff told us, and records confirmed that one to one meeting's, known as supervisions were conducted. A senior care staff member told us that they completed supervisions with care staff. Supervision sessions are used, amongst other methods to check staff progress and provide guidance. When asked if they received training in supervision they told us, "I've done my level 3 training, and I listen and learn from others. The manager at [another care home] observed me doing supervisions."

Care records included information on contact with health professionals such as the district nurse and chiropodist. Reasons for visits were documented and action taken by health professionals was recorded. The registered manager also explained that a GP visited the home once a week to visit people. A senior care staff member explained that they would contact the GP or nurse for advice or home visits if they felt someone was unwell.

When staff were asked how they support people whose behaviour may be challenging they told us they look for triggers to the behaviour. For example an infection, change of routine, changes to patterns of behaviour. One staff member said, "Distraction techniques are tried. The one person does have a prescribed sedative but distraction techniques work most of the times. We involved the mental health team, medicines are checked and we look for triggers." A senior care staff member told us, "There's no need to restrain anyone, it's managed by distraction." This meant people were not unduly being deprived of their liberty and staff were using appropriate methods to support people to manage their behaviour.

The restraint policy was dated September 2014 and stated there would be, 'ongoing training and early refresher courses. Staff are trained in interventions. The training includes de-escalation; the concept and use of minimum force; approved and acceptable break away techniques; inappropriate and unacceptable techniques.' This policy included DoLs. We did not see any evidence in staff files or on the training matrix that staff had received any training in restraint or interventions.

One person told us, "Food's alright, you can have whatever you want more or less." Two other people we spoke with told us that the food had been cold recently and that they had tried to send it back but staff refused to put in the microwave and hadn't explained why they wouldn't do so. Our observation of lunch time showed that people were receiving hot food and drinks and staff were responding to people's individual requests. One person asked for a small apple pie for dessert and staff immediately went into the kitchen to see if they had one. Another person said they didn't like ice-cream so were offered custard instead. No one complained about the food.

Tables were nicely set and arranged. People were sitting together and socialising. Staff were attentive and offered people a choice of meals. They asked if people had finished or would they like another portion. None of the people we observed needed physical support with eating their meal. We saw that staff responded when then saw someone struggling to cut their meat up and offered appropriate support in a discrete manner.

Requires Improvement

Is the service caring?

Our findings

One person told us, “The staff are alright, they offer cups of tea but I enjoy water. I'm offered biscuits and I enjoy them in my room.” Another person told us, “It’s good living here, the staff are nice.”

Another person told us, “You can only have a shower once a week here. I couldn’t have one last night because they were short staffed.” We viewed this person’s care records and saw that they had only had one shower in December and four in January. This person’s assessed need stated that they had been known to neglect their hygiene needs and therefore required assistance. Given that it was known that this person experienced incontinence and needed prompts and assistance with showering records indicated they were not being supported to maintain their dignity given the personal care offered them.

We saw in another person’s care records that a family member had raised concerns in relation to personal hygiene and bed baths. We reviewed personal care records and saw that during January 2015 they had three showers and six bed baths and in December 2014 three showers and one bed bath. It was recorded that this person was doubly incontinent, wears continence pads and cannot mobilise. The risk assessment for personal care stated ‘risk of poor hygiene standards, loss of dignity and sore areas of skin. Given the person’s personal care needs and the acknowledged loss of dignity and risk of skin integrity records for bathing would suggest there was a clear risk that this person’s dignity was not being maintained.

We observed one person walking to the staff member in the dining room with their trousers undone. The person said they were uncomfortable, attempted to tuck their clothes into their trousers and did their trousers up. Care staff asked if they needed any help and the person undid their trousers again and started adjusting their clothes in the dining room in full view of other people. The staff member observed them do this several times and commented about their clothes being uncomfortable but did not support the person to a private space in order to maintain the person’s dignity and respect.

We observed that other staff had good, warm relationships with people and they went about their work showing care and concern for people. For instance, we observed care staff take time and care to reassure and assist one person who was having a late breakfast. Staff chatted with people. We saw people enjoying songs being performed in the lounge area.

Despite seeing a lack of respect and dignity in staff approach the staff we spoke with had a good understanding of the importance of treating people with dignity and respect. They gave us practical examples of how they delivered care to achieve this aim. For example, making sure people were dressed how they wanted to be, making sure doors and curtains were closed when helping with personal care, keeping people covered up and respecting people’s rights and choices. Staff also told us how they promoted people’s independence by allowing them to do things for themselves if they were able.

The registered manager was asked whether anyone had an advocate and they said, “No one has an advocate but there are posters on display advising who people should approach.” The registered manager went on to explain, “We were going to introduce one to one discussions with residents so we would remind people about things like advocacy, concerns, and fire regulations then.”

Inadequate

Is the service responsive?

Our findings

One person told us, "I have epilepsy, staff help with tablets but I take them myself. They give me my tablet to take with me if I'm going out." We reviewed this person's care records and their medical history sheet stated they had 'epilepsy and mental retardation'. There were no care plans or risk assessments in relation to epilepsy found. There were no monitoring sheets, no background information and no reviews in evidence. We did not see any evidence of involvement from a specialist in epilepsy. When this was raised with one of the registered managers they said, "I know what you are going to say, I've raised it before." They added, "It's the terminology [This was in reference to recording 'mental retardation.'] that the doctor used so we felt we had to use it."

We reviewed another person's care records. We found that it included a mobility care plan dated 11 March 2012 which included the use of a hoist. This document was evaluated every month but no new care plan had been written. There was evidence of this person experiencing several falls but this hadn't triggered an update of the care plan. A 'temporary care plan' had been put in place on 22 December 2014 for the use of a profile bed and bed bumpers. This recorded that a referral had been made to the occupational therapist for assessment and a referral to the district nurse for bed rails. This suggested there had been a change in need and circumstance but the mobility care plan remained as written in 2012. There was no evidence of a robust risk assessment for mobility or the use of the profile bed or bed bumpers. This meant people were not protected from inappropriate or unsafe care because care was not planned to meet their individual needs. This also meant risks to people's safety were not being managed appropriately.

We saw a care plan for specialist equipment which related to use of a wheelchair, hoist and sling and bath chair. The care plan stated 'follow instruction set out by occupational therapist'. We saw no evidence that any risks associated with the person's mobility and their use of specific equipment had been assessed. This meant the person and care staff were at risk from using equipment that had not been appropriately care planned or risk assessed.

We saw another person who was using a walking aid (frame). There was no reference to this in the persons care plan and no record of the appropriate professionals being consulted with. This meant care plans had not been updated to reflect people's current support needs.

We saw further evidence of a lack of information within care records. A care plan for pressure risks stated to turn the person every three hours when in bed using the slide sheet and ensuring trained techniques are used. There was no mention of the trained techniques and no written guidance on how to use slide sheets. This meant people were at risk of not having their needs met appropriately and safely.

The same person had a care plan for overnight support which stated staff should complete four hourly continence checks and two hourly health and safety checks. If followed alongside the pressure risk care plan this person would have been checked every two hours for health and safety, turned every three hours and checked for continence support every four hours. This is potentially confusing for care staff and could have impacted on the quality of sleep the person received placing them at further risk of harm due to falls or confusion.

Another person's overnight support care plan was dated 11 February 2014, 18 April 2014 and 7 May 2013. This plan stated that the person had asked care staff to check on them during the night as it made them feel safe and secure. A typed entry on the care plan stated to check the person four hourly but a hand written entry stated to complete two hourly health and safety checks. The handwritten entry was not signed or dated. This document evidenced a clear change in the person's need but a new care plan with specific information about the timing of night time checks had not been produced which resulted in a care plan that contained contradictory and confusing information for care staff to follow.

People were not appropriately protected against the risks of receiving care that was inappropriate or unsafe. Assessments of need in the form of care plans and risk assessments had not been appropriately updated to reflect people's current needs and therefore put the welfare and safety of people and care staff at risk.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service responsive?

The home employed an activities coordinator. They told us, “We do chair exercises, then bingo and this afternoon we are making pizza.” One person said, “We have a knitting class on a Thursday morning. Staff tell you what’s happening, sometimes play bingo but more often I go to my room.” Another person said, “I used to work in the kitchen but I didn’t like it. I do arts and crafts now. [The activities coordinator] is good.” We observed eight people in the lounge playing bingo with the activities coordinator. People were very engaged and focused but it was noted there were no other staff observed in the area to support people.

One person told us they were, “Quite satisfied, no complaints, staff are pleasant.” We saw a book which contained complaints and concerns from people living at Four Winds Residential Home and how they had been responded to. These concerns were mainly around meals being cold. Responses were that food would be replaced if it was cold. We observed lunchtime and saw that the food was hot and staff were responding to any additional requests people made.

We saw a quarterly analysis of the number of issues broken down by laundry, meals, care, environment, and resident issues. It was identified whether the issues could have been avoided – this was recorded as no; whether the issues had been rectified, which were recorded as yes and could we [Four Winds] have done better which was recorded as not applicable. Analysis of complaints could have been more robust in terms of patterns of complaints and triggers, for example in addressing complaints about the food.

A resident and family meeting had been held in November 2014 where people had been asked for ideas on the winter menu. In the December meeting the winter menu had been agreed and an update had been given on activities and fire evacuation. The complaints policy had been discussed. A further meeting had been held in January 2015 where activities and suggestions had been discussed.

We saw that satisfaction questionnaires had been sent to two people each month but there was no evidence of any record of changes made or lessons learnt.

Inadequate

Is the service well-led?

Our findings

At the time of the inspection there were two registered managers employed at Four Winds Residential Home. One of them described their role as being, "Managing, ensuring health and safety regulations are adhered to for staff and residents. Continuity of care and making sure each resident is delivered a person centred approach. Meeting with family and residents on admission to write a full and comprehensive care plan on assessed need. Ask each resident to sign and say in agreement with care plan. Ensure the business is fit for purpose."

Providers are legally obliged to send the Care Quality Commission notifications of certain changes, events or incidents. We found the provider was not meeting this obligation. For example, we found since November 2014 three people living in the service had been admitted to hospital and had unfortunately died. Statutory notifications of these deaths had not been submitted to CQC. Both registered managers told us, "We did not know we had to notify for deaths in hospital." On day one of the inspection we saw a sign on the main entrance door advising visitors of a diarrhoea and vomiting outbreak within the home. CQC had not been notified of this significant event. A senior care staff member rang CQC for advice and was informed to complete a notification. The required notification was received on 6 February 2015. A failure to notify CQC meant the registered managers were not fully aware of their responsibilities. This matter is being dealt with outside of the inspection process.

We received mixed feedback about the provider's approach to quality assurance. One of the senior care staff told us, "The operations manager and the owner pop in and do audits or spot checks." When asked about quality assurance and audits one of the registered managers told us, "We don't do audits". When asked about action plans for service improvement the registered manager said, "Care plans have a progression and evaluation recorded on a monthly basis. There's a matrix the seniors complete. We don't have action plans written down but we do regularly go through files."

Senior staff completed a daily check of documents including the diary, fridge temperature, wheelchair chart, bed and bath chart. All entries were ticked but there was no place to record any concerns or action taken. Entries were not signed so there was no accountability evident. There was no evidence of registered managers checking that this had been completed and no management oversight in that the registered managers were not auditing this checklist.

We saw evidence of a monthly senior staff member checklist in each person's file. This included the date of the check and each month there was a tick against the following headings: care plans checked, monthly review of care plans completed, weight and water flow. There were columns titled action required and action completed but these were generally blank. There was action noted in one person's file on 2 November 2014 that an October weight was missing from the file. An additional comment on 18 November 2014 stating this had been completed and record keeping had been discussed. A further action was recorded on 2 December 2014 to say care staff were to be informed to complete updates but there was no entry to indicate this had been completed.

There was no evidence of any registered manager oversight of this process or sign off of actions.

Night time security checks were completed by senior care staff on doors and lower floor windows at 10.30pm every evening. This document was signed each night to say checks had been completed but there was no space to record any comments or faults or action taken. There was no evidence of managerial oversight.

A health and safety checklist was completed from week commencing 12 January 2015. There was a task a day such as window locks on Mondays, lighting on Tuesdays. On 12 January 2015 it had been recorded that a person's window opened too much and the window in the dining room needed to be checked. This document did not include detail of any action taken to assess or repair the window to ensure it was safe and fit for purpose. On 19 January 2015 it was noted that a different person's window had been checked and it was recorded that 'all other windows were fine'. When asked the registered manager said, "Oh, we have a maintenance file where work would be logged." We did not see evidence of a maintenance file.

We saw a quality assurance policy dated September 2012. This stated, 'The service will have a continuous development plan for quality improvement, based upon feedback from users, staff and others. It will be agreed live with ongoing commitment to continuous development. It

Inadequate

Is the service well-led?

is regularly reviewed, amended and added to." We did not see any evidence of a continuous development plan. When asked about a service improvement plan the registered manager did not respond.

When asked if they had any evidence of lessons learnt from incidents or surveys the registered manager said, "We do monthly incident analysis." This was a document that recorded the number of falls over the month. When asked if they reviewed this for triggers they said, "We only record the numbers of falls over the month." The registered manager was asked about further analysis in terms of lessons learnt or action plans. They said, "No, we don't do anything like that." When asked whether they used the analysis to identify triggers, like loose carpets or change in support needs they said, "No, no we don't."

The registered manager provided us with a policies and procedures file and we saw that policies were in place but noted that none of the policies were version controlled. They were all signed on an annual basis as being reviewed but there was no evidence of policies being updated or re-written in line with current legislation. For example we saw there was safeguarding information for users with review dates and a signature in August 2012, 2013, 2014. There were no amendments to policy and no version control. This meant staff could be following procedures which were not in line with current legislation and guidance.

We did not see any evidence of policies relating to the Mental Capacity Act (2005) or Deprivation of Liberty Safeguards.

Whilst senior care staff were completing some quality checks and audits they were not robust in terms of recording concerns and action taken. There was no evidence on any documentation that the registered managers had oversight of these processes or were completing a full service audit in order to produce an improvement plan. People were not protected against the risks of inappropriate or unsafe care because the quality of the service was not regularly and robustly assessed and monitored.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A staff member told us, "We are definitely well supported, doors always open and managers always have five minutes for you. There's a close knit group of staff and managers." The registered manager told us, "We have an open door policy." A senior staff member said, "We get asked our opinion of paper work and processes and we can have input into it. Management are open to suggestions for change and what staff find easier to use as long as it covers the requirements."

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not being protected against the risks of receiving care that is inappropriate or unsafe. Assessments of the needs of people were not current so did not meet individual needs or ensure the welfare and safety of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected against the risk of the unsafe use and management of medicines. There was no safe system in place for the recording and administration of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining and acting in accordance with, the consent of service users in relation to the care provided for them in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff People were cared for by staff who were not always supported or trained to deliver care safely and to an appropriate standard. Regulation 23(1)(a).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

The enforcement action we took:
We took enforcement action which resulted in the cancellation of the providers registration.