Leonard Cheshire Disability

White Windows - Care Home with Nursing Physical Disabilities

Inspection report

Fore Lane
Sowerby Bridge
Halifax
West Yorkshire
HX6 1BH

Tel: 01422831981
Website: www.leonardcheshire.org

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection of White Windows took place on 22 and 28 January 2019 and was unannounced. At the last inspection in October 2017, the service was rated as requires improvement and identified two breaches of regulation which related to safe care and treatment (medicines management and risk assessment) and good governance. Following the last inspection, we asked the provider to complete an action plan to show what they would do to achieve compliance in these areas. The provider did this in a timely manner. However, during this inspection we found the service was still in breach of these regulations and we found further breaches of the Health and Social Care Act 2008 associated regulations. These were in relation to meeting people's health needs and person-centred care, staffing, consent, person centred care and privacy and dignity.

White Windows is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package. CQC regulates both the premises and the care provided, and both were looked at during this inspection. White Windows has four floors with living accommodation on two floors which are accessible by a lift. The home is registered to provide accommodation for up to 25 people and there were 23 people living in the home during our inspection.

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

Nursing staff were knowledgeable about safeguarding people but not all care staff we spoke with understood what might constitute abuse and what they should do if they thought someone was being abused.

Medicines were not managed safely. Some medicines and essential items were not available and some people did not receive their medicines in line with their needs.

Risks to people's health and wellbeing were not well managed. Risk assessments were in care files but many of these were generic. More personalised risk assessments were not always up to date. People at risk of pressure damage were being nursed on mattresses for which staff did not know the correct setting. Accidents and incidents that happened in the home were not analysed to look at ways in which the risk of similar events could be minimised.

There were not enough staff available to meet people's needs safely. Staff received the training they needed but did not always feel the systems for supervision were effective.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible. Mental capacity assessments had not taken place and conditions

on Deprivation of Liberty Safeguards (DoLS) were not being met. We did not see any evidence of people's independence being supported.

People enjoyed the food at the home but we found people were restricted in being able to make drinks and snacks independently.

People's healthcare needs were not always met effectively and people had been put at risk due to this.

Practices within the home did not always support people's privacy and dignity needs. One person described the service as "institutional." Some staff demonstrated a caring approach.

Care was not consistently planned or delivered with a person-centred approach. People were not supported to follow their lifestyle choices and access to appropriate activities was minimal.

The provider had not complied with the Accessible Information Standard (AIS), which sets out a specific approach to meeting the information and communication support needs of people with disabilities, impairment or sensory losses.

Systems for auditing the safety and quality of the service were not effective and did not include the views of people who used the service.

We identified six breaches of regulation. These were in relation to safe care and treatment, staffing, consent, person centred care, privacy and dignity and good governance.

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.

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

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

Medicines were not managed safely

Risks to people's health and wellbeing were not managed.

There were not enough staff available

Is the service effective?

Inadequate

The service was not effective

People were not supported to have maximum control and choice.

Staff received training but the system for supervision was not effective.

People enjoyed the food at the home but were not able to access snacks and drinks as they chose.

People's healthcare needs were not always met effectively and safely.

Is the service caring?

Inadequate

The service was not caring

People's privacy and dignity needs were not met.

People's independence was not supported.

Some staff demonstrated a caring approach.

Is the service responsive?

Inadequate

The service was not responsive

Care was not planned or delivered with a person-centred approach

People were restricted in their lifestyle choices and had did not have access to appropriate activities

Is the service well-led?

Inadequate

The service was not well led

Auditing of the safety and quality of the service was not effective.

People were not actively involved in the running of the service.

White Windows - Care Home with Nursing Physical Disabilities

Detailed findings

Background to this inspection

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

This inspection took place on 22 and 28 January 2019 and was unannounced. The inspection team on the first day consisted of two adult social care inspectors, a medicines inspector and an 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. On the second day the team consisted of three adult social care inspectors.

Prior to the inspection we requested a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was completed and returned within the requested timescale. We checked information held by the local authority safeguarding and commissioning team and the local Clinical Commissioning Group (CCG) in addition to other partner agencies and intelligence received by the Care Quality Commission. The commissioning team sent us the report of their inspection in September 2018. They had found the service was not fully compliant in all the areas they looked at.

We spoke with ten people using the service and five of their relatives. In addition, we spoke with nine members of staff including support workers, nurses, the cook, the activities organiser, the registered manager and the regional manager.

We looked at six sets of care records in detail including risk assessments and records in relation to

Deprivation of Liberty Safeguards for people who had authorisations in place. We also looked at five staff records, all training records, minutes of resident and staff meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Inadequate

Is the service safe?

Our findings

When we inspected White Windows in November 2017 we identified breaches in relation to medicines management and risk assessments. We checked to see if the service had achieved compliance in these areas.

Since the last inspection the service had started to use an electronic system for managing medicines. Staff told us this could be problematic because the system relied on a connection to the internet which was variable throughout the building.

We found medicines were stored safely and daily checks were made on controlled drugs. These are prescription medicines containing drugs which are controlled under the Misuse of Drugs legislation.

Medicines were not always administered safely. We observed a nurse administering medicines and found that one person was given their medicines in a reclined position. The person's care plan stated for the person to be sitting up to take their medicines. Taking medicines in a reclined position may have made it more difficult for the person to swallow their medicine.

People were not always receiving their medicines as prescribed. One person had their medicines administered into a stomach tube as they were unable to take their medicines by mouth. The care plan lacked the detail needed from a pharmacist to explain how each medicine should be administered. We saw this person was unable to have a medicine to protect their bones on two occasions due to the medicine being unavailable in the home. We saw the nurse ask another person to chew one of their medicines to aid swallowing, however the medicine chewed was a slow release medicine, which should not be chewed.

One person who had recently been discharged from hospital was self-medicating. The Medicines Administration Record (MAR) sheet had not been completed by the home to state that the person was self-medicating and the MAR was incorrect as it had not been updated to reflect the medicine changes from hospital.

We found that the home did not have a safe process in managing medicines for people who left the home on social leave. One person had missed three of their lunchtime medicines as they were on social leave and another person had missed four tablets of their lunchtime medicines as well. The home had not checked with either person's doctor or pharmacist to see if their medicines could have been given at a different time, which would have prevented a missed dose.

One person told us staff had failed to administer their eye drops as prescribed and this had resulted in swelling and a build-up of pressure in the eye. They said, "This was only sorted out when I went back to see the surgeon. It was just luck that I had an appointment planned for that time." This person also told us they were "not allowed" to have Paracetamol to manage pain issues. The person was not aware of any reason for this and told us their visitor "smuggles it in."

Another person told us, "They're [staff] not getting my blood testing strips, these test my blood sugar levels and ketones. They've run out so they're using other people's and a spare machine but these don't measure my ketones." Staff confirmed this was correct and said the correct strips had run out two weeks ago. We made a safeguarding referral in relation to this issue.

We found strips for testing urine were out of date, as they had an expiry date of September 2018.

This meant the service had failed to achieve compliance in this area and is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's health and wellbeing were not well managed. Risk assessments were in care files but we found many of these were generic. More personalised risk assessments were not always up to date. For example, on the first day of our inspection we looked at the risk assessment for a person's skin integrity which showed they were at very high risk of pressure damage. A body map, completed following a stay in hospital, showed the person had areas of significant skin damage but we found the associated risk assessment had not been updated. We saw the person was being nursed on a pressure relieving mattress but this was not detailed on the risk assessment. There were no details available to show what pressure the mattress should be set at and when we asked a nurse about this they were unaware of the pressure settings for the mattress and did not know what the correct setting should be. This meant the risks of further pressure damage for this person were not being managed.

When we returned for the second day of our inspection the regional manager told us they had asked for a review of all air mattresses being used at the service. The review showed a further ten people were using air mattresses which staff did not know the correct settings for. We saw daily mattress checks which staff had signed to say the mattresses were at the correct setting despite the correct setting not recorded. The regional manager told us these were, "Not worth the paper they were written on." We looked at mattress audits dated July and December 2018 and found these did not include checks on settings for air mattresses We made a safeguarding referral in relation to this.

We saw some new documentation was being introduced and we looked at the risk assessments developed for one person using the new format. We saw the risks to people were rated with red, amber and green (RAG rated) and provided good information for staff to follow when completing the assessment. However, we saw staff were not working in line with the risk assessment to reduce the risk of the person choking.

This meant the service had failed to achieve compliance in this area and is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Safe care and treatment).

Staff and people who lived at the home expressed concerns to us about staffing levels. One member of staff told us the staffing situation was "dire" and said staff were "really tired." Another staff member told us that shift patterns had been changed by the registered manager without any explanation. They said they were now working irregular shift patterns which meant staff worked a variety of early and late shifts and were not always getting two days off together. They told us, "Staff are getting tired & poorly." A member of staff told us, "We're always rushing to get everything done."

A person living at the home told us, "In the evening they [the home] have four care staff and a nurse. The care staff have half an hour break. Two go at 5.30pm which leaves just two on the floor, when they come back the other two go. Staff are stretched, we could do with five (staff)." They also told us, "Lots of staff have left, some in tears, seem stressed."

We saw most people living at the home required the support of two staff to meet their care needs and staff told us six people needed support to eat. This meant there were not enough staff available to support people with their evening meals and when staff were taking their breaks, when two staff were supporting a person with care needs, there would be no staff available to support other people.

During our inspection we observed a lack of staff availability in communal areas. On one occasion we had to look for staff to support a person who was becoming distressed because they urgently needed support to use the toilet.

Staff and people who used the service also expressed concerns about the amount of agency staff being used. One staff member said, "I've had times when there's been three agency staff on and only one of our own staff." They told us an 'on-call' system was in place but staff on call did not come to help during staff shortages. Staff also expressed concerns about insufficient laundry and cleaning staff.

Our analysis of staff rotas showed usual levels to be six care staff and a nurse in the morning and four care staff and a nurse during the afternoon and evening. At night there was one nurse and two care staff. This meant staff would only be able to support one person at a time during the night. Rotas confirmed high use of agency staff including occasions when two of the three night staff were from an agency. The registered manager told us they were trying to recruit to vacant positions. We also saw from rotas covering a four week period, three weekend days where no cleaning or laundry staff had been on duty.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Staffing).

Our review of three staff files showed appropriate checks such as references and a criminal record check through the disclosure and barring service (DBS) were made prior to the offer of employment. However, we noted that poor references and dates of employment on references which did not align to those stated on the application form had not always been explored.

We recommend the provider puts systems in place to make sure applications for employment are scrutinised and record is made of exploration of poor references or those which do not align to the dates of employment stated on the application.

Nursing staff understood safeguarding and what to do if they thought someone was at risk. However, not all of the care staff we spoke with understood what might constitute abuse and what they should do if they thought someone was being abused.

The registered manager told us they had a system in place for analysing accidents and incidents within the service. However, when we looked at this we found it to be a collection of data with no analysis which would help the registered manager to look at ways in which the risk of similar accidents and incidents could be minimised.

We found the premises to be generally clean and tidy and saw staff used gloves and aprons appropriately.

We saw routine maintenance and servicing of installations and appliances was carried out regularly, including for the passenger lift, electrical installation, water and gas systems.

Inadequate

Is the service effective?

Our findings

When we inspected White Windows in November 2017 we found best practice in relation to managing DoLS authorisations was not consistently followed. We recommended that systems be put in place to audit compliance with DoLS conditions to make sure they were met. We checked to see if improvements had been made.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

The provider had not undertaken any capacity assessments, although there was documentation relating to capacity and best interests for broad areas of care. These were not specific decisions that a person may need to make. For example, we saw capacity assessments relating to, 'eating and drinking,' 'general health,' and 'cognition, thinking, understanding and remembering.' For each decision we saw the provider referred to the presence of an authorised DoLS as evidence of a lack of capacity. In one care plan we saw this resulted in the person being recorded as lacking in capacity to choose what they ate. When we asked the registered manager about this they told us this was not the case, meaning staff may have used incorrect information to limit the person's right to make choices. Another care plan contained reference to a DoLS in relation to the person's capacity, however the authorisation date quoted was for a DoLS which had expired.

We saw the process to authorise one person's DoLS contained a condition that the service undertake capacity assessments, this had not been done. This meant the provider had failed to act on information which could have improved the assessment and recording of capacity for all people who used the service.

The registered manager had a tracker which showed who had an authorised DoLS in place and the date by which it would need renewal. Although the registered manager was aware that some people had conditions attached to the authorisation of their DoLS and had marked these as having been met, we found insufficient action had been taken to meet these conditions. We raised this with the registered manager at the end of the first day of our inspection, however when we returned for the second day the following week we found they had taken no action to ensure the service was meeting this legal requirement.

We spoke with an advocate who was visiting two people living at the home. They told us, "They (staff at the

service) really don't understand capacity and choice." In relation to one of the people they were visiting, the advocate told us, "There is no understanding of how (name) communicates (their) decisions. I asked staff about this when I first started coming and they had no idea. I have seen a variety of practice. Some staff ask for consent but others, particularly nurses, I have seen just walk into (person's) room without asking or being invited in."

People told us about how their choices were restricted. For example, two people told us how they would like to have a bath every day and at a time of their choice but were not able to do this. Two members of staff told us they followed a bath list which showed who has a bath on which day, they told us, "All baths are done in the morning."

We saw one person had an end of life plan in place which contained specific details of the treatments they consented to and those they did not. We saw the plan referred to the person's personal care plan for details of a treatment the person had consented to. We asked the deputy manager what this treatment was and where it was detailed. The deputy manager told us they did not know what the treatment was and could not find any information about it within the care plan. This meant staff had not taken the action required to make sure the person's wishes and choices would be met.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Need for consent).

We spoke with a visiting health care professional who told us they found staff at White Windows to be unwelcoming and said although staff had requested them to visit, they often had to wait for staff to support them in attending people. They told us staff did not always follow their advice.

One person told us how a nurse had prevented their social worker from reading their care plan. The person told us the nurse had to be persuaded to let the social worker see their care plan.

We found staff did not always respond to people's health care needs effectively. One person with diabetes told us about how staff had failed to check their blood sugar levels on two consecutive days when they were feeling unwell. The person told us they had to be admitted to hospital as an emergency the following day with very high blood sugar levels and other complications relating to diabetes. We looked at this person's records which confirmed this. Records showed the person was given orange juice to drink when they complained of feeling unwell and their temperature was taken but no record of blood sugar checks. Records from the hospital stated the person had been drinking concentrated apple juice with high sugar content.

We saw the person's diabetes care plan dated January 2019 said, 'blood glucose to be tested four times a day with BM/Ketone strips two in one. Ketones aim to keep 0.6 if elevated seek medical assistance or if (person) appears unwell.' We spoke with two nurses about this. Both said they knew nothing about testing ketones and had not done it. One nurse said, "I think we only need to do it if (person) goes hypo (Low blood sugar)." The nurses confirmed the ketone strips been out of stock for thirteen days.

We saw one person had been admitted to hospital with a blocked bowel. We looked at this person's records which showed they had not had a bowel movement for a period of twelve days in the two weeks prior to their admission to hospital. There were no records to show this had been identified as a potential issue and therefore no intervention had been made.

We saw a fluid balance chart to measure whether the person was sufficiently hydrated. Their fluid intake and

outtake were unclear and when staff were asked to explain, they could not do so. Not having a correct fluid balance chart may increase the risk of a person becoming dehydrated. This issue had been highlighted as an area of non-compliance during the inspection completed by the commissioning team in September 2018.

Nursing staff failed to demonstrate competence in making sure people's healthcare needs were met safely. This was evidenced in the failure to check blood sugar levels, failure to check ketones and failure to recognise the signs of symptoms of a blocked bowel.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Person centred care).

People told us they generally enjoyed the food at the home but said this often depended on who the cook was. One person said, "Food is excellent, we get a choice." We saw most of the meals offered looked appetising and nutritious. However, we saw little effort had been made to present food for people who required a soft diet in a way which would help them to identify the components of the meal. We spoke with the cook who showed us the information they held about people's nutritional needs.

People took their meals either in the dining room or in their own rooms. There was no provision for people who might like to eat in smaller groups, for example, in either of the two lounges. Staff told us six people needed support with their meals. We saw staff sat with people to give support but did not always interact with the person they were supporting.

Two people told us mealtimes were inflexible and too close together. One said the timings did not support their nutritional needs.

We saw people were served drinks during the morning and mid-afternoon. No snacks were offered with the drinks. When we asked people if they would like a snack one said, "I would but we are not allowed," another person said, "We never get anything," People told us they were not able to make themselves a drink or snack. We saw minutes of residents meeting which said, 'During the day drinks will be served at 10.45 and 2pm with the trolley prepared in the kitchen ready for the carers to take out.

We saw minutes from a catering meeting in November 2018 which said, 'There have been instances of a service user's family entering the kitchen when everyone had gone home to use the boiler/cooker. The kitchen door into the dining room will be kept locked after 6pm to prevent anyone going into the kitchen. The door leading into the corridor will remain open for staff. There are facilities at the far end of the dining room for families.' We saw a kettle was available but no supplies for people to make a drink. Nothing was available to enable people to make or access a snack.

The registered manager told us new staff followed an induction process which included the completion of the Care Certificate which is a national set of minimum standards for all staff new to care. Staff then followed a programme of training in areas relevant to their roles.

Staff told us they received training which met their needs. One member of staff had completed 'train the trainer' in moving and handling and we saw they trained other staff within the home to deliver this training. The training matrix we saw evidenced staff were up to date with the training they needed to support them in their role. However, we found staff were not always working in line with their training and not all staff understood safeguarding despite having received training in this area.

We recommend the provider includes checks on staff competency and understanding of training during supervision.

Staff we spoke with gave variable feedback about the processes in place to ensure they gave and received operational and clinical support. One member of staff told us, "We're supposed to have supervision every two months, then I'm supposed to supervise the care staff, not given any extra time to do this, it's hard work trying to juggle everything. There's no support for us, I don't get any clinical supervision." Records we looked at showed that clinical supervision sessions lacked evidence of meaningful support and development. The registered manager told us staff received regular supervision during their induction, however files we looked at did not evidence this.

We spoke with the registered manager about supervision activity. They told us they had been working with the responsible staff to improve the frequency of supervision meetings, and meeting minutes we saw confirmed this. We saw the commissioning body had raised this as an issue at one of their monitoring visits in September 2018.

We asked the registered manager how technology was used to support people. They told us they had a large remote control on a stand in one of the lounges and that one person had an iPad to help them with communication. We did not see the iPad being used and the person's advocate told us they had never seen it in use.

We saw people had large bedrooms and corridors accommodated ease of movement for people using wheelchairs. However, we saw the lounges had large items of furniture which presented issues when a few people using wheelchairs wanted to be in the room. One person told us they thought the lounges were for people to use with their visitors and for staff.

People told us it was not easy to access garden areas in wheelchairs and we saw a ramp into the garden was broken.

Inadequate

Is the service caring?

Our findings

We found practices within the home did not always support people's privacy and dignity needs.

One person told us there was no bathing trolley available in the home to enable them to bathe comfortably and with dignity. They said, "I have to undress in my room and then I am taken on a commode to the bathroom. I am covered with towels."

Staff told us they had not had a bathing trolley for over two years and confirmed people had be undressed in their rooms and supported into the bathing sling. They told us they were covered and taken to the bathroom in their wheelchair. Staff said it was difficult to support people to bathe properly when in the sling. Staff said that after bathing, people had to be seated back in their wheelchairs in the wet bathing sling and taken back to their bedroom to get dried and dressed. This meant their wheelchairs got wet.

The regional manager told us there was no issue with obtaining a new bathing trolley but was unaware the service didn't have one.

We saw staff did not always interact with people appropriately. We observed several incidences of staff moving people in their wheelchairs without any interaction, explanation or consent from the person. We saw one staff member support a person into the dining room in their wheelchair. The staff member supported the person to drink from an adapted cup. There was no interaction from the staff member who only spoke with a colleague. As soon as the cup was empty the staff member wiped the person's chin with a paper towel without asking or speaking to them and walked away. On another occasion we saw a staff member set up a person's feeding system in the lounge without any interaction with the person.

We observe one member of staff supporting a person to eat who was not able to hold their head up independently. The member of staff repeatedly pushed their hand into the person's forehead to push their head into an upright position. The registered manager told us this was an agency member of staff and confirmed appropriate action had been taken. However, the practice had not been challenged by any of the service's own staff in the vicinity.

One person told us, "People just get dumped in (communal) rooms. It's not their choice where they are. It's institutionalised."

We did not see any evidence of people's independence being supported. One person told us, "I had friends visit recently. I opened the door to let them in and (registered manager) went mad at me. If we go outside the building we're not allowed the key code to get back in, we can be waiting ages for staff to come and open the door.

Another person told us they had been informed, prior to admission, that they would be able to cook for themselves. They said, "I've never been able to do that as the kitchen (area within the dining room with cooker and kettle) doesn't work. I'm not even allowed to make myself a cup of tea. Someone has to do that

for me. Life would be easier if I could cook here."

One person told us they would be much more independent with personal care if they had access to a wet room. They told us some people had en-suite wet rooms but they had been told by the registered manager those people paid for that facility.

Religion or belief is one of the protected characteristics set out in the Equalities Act 2010. Other protected characteristics are age, disability, gender, gender reassignment, marital status, pregnancy and maternity status and race. We saw from one person's care records that they had expressed a wish to attend the church they were part of prior to admission to the home. We saw this had happened on only one occasion. One person's care file included reference to medical procedures they would and would not consent to in line with their faith. We asked a senior member of staff if they were aware of this and they said they were not.

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

Some of the staff we spoke with demonstrated a caring attitude and told us they would like to have time to spend with people. A relative we spoke with said of the staff, "They are lovely, kind and caring."

Inadequate

Is the service responsive?

Our findings

Some of the care documentation we looked at had been written in a person-centred manner and from the point of view of the person. For example, care plans included sections titled such as, 'Things you need to know about my general health' and 'Things you need to know about my emotional health and wellbeing.' We saw care plans contained some good detail about the support people needed and how they would like to receive this support. However, we saw little evidence of people being involved in the care planning process. One person told us, "My new care plan was written in December [2018] but I have never seen it."

Care plans had not always been updated to include changes to the person's care and support. For example, we saw the QUEST (NHS community service) matron had been asked to look at a person's sore skin. The advice from the QUEST matron had been included in a review of the care plan but the care plan had not been updated to reflect the advice and recommended management. We saw where a person had returned from a stay in hospital, their care plan had not been updated to reflect their changed needs.

New style care documentation was being introduced and one person's care file had been updated with the new documentation. We looked at this and found the documentation was designed with a person-centred approach and included a one-page profile of the person, a section titled 'Things people like and admire about me' and questions about the person's preferences in relation to how they received their care. Support needs were documented under the heading 'My goals and outcomes.' However, we found the information inputted by staff lacked necessary detail. For example, one person's goal detailed within their plan was for the person to maintain flexibility to their limbs. The care plan said the person 'requires daily passive exercise to maintain and potentially improve flexibility of upper and lower limbs.' No detail was given about how staff would provide this support and there was no evidence of professional advice about how to do this. We asked a member of staff if they knew how to support this person with their exercises. They said they did not know.

We saw staff were not always working in line with people's care plans. For example, one person's care plan said they needed to be given their medicine and supported with meals and drinks in an upright position. Our observations over two days were that this was not followed.

People told us they did not receive their care and support in a person-centred manner. One person told us, "You have to fit in with the regime here." They told us they had chosen not to have checks at night but were still receiving them. They said, "One of the bank staff came in and put the light on at 2am."

Another person told us how staff did not give them the support they needed in a timely way to enable them to be ready for their activities outside of the home. They also told us how staff did not always respond to their pressure care needs. They said, "If it's a good team they will get you in bed straightaway, others will say it's not a priority."

One person told us they didn't have a keyworker and another said, "I have a keyworker, don't know who it is. (Registered manager) reallocated them a couple of months ago, I'm not asked about it."

People told us they were not supported in meeting their social and recreational needs. We asked two people what they were going to do on the first day of our inspection. One said, "Nothing, as usual," and another who was not able to communicate verbally rolled their eyes.

Another person who had difficulty with verbal communication showed us pictures of their spouse' grave. We understood from the person's non-verbal communication that they would like to visit the grave. When we asked about this they became emotional and nodded their head. We asked if they had ever been supported to visit the grave, the person became very emotional and shook their head.

One person told us, "I feel very isolated here, I spend a lot of my time in my room. I don't have Wi-Fi in my room, I have raised it with (registered manager) but I have to pay if I want it."

We spoke with the activities organiser who told us they also managed a team of eight volunteers. They told us there was a trip out every Thursday because this was when most volunteers were available. They said six people could be supported to go on the trips and that week they were going to a local cinema to see the film Collette. We asked how it was decided who was going and the activities organiser said, "They [people] come to see me or hear about it on the grapevine." We asked who decided what films to go and see the activities organiser told us they looked at the programme for the month and then they decided, they said, "Some films wouldn't be suitable for them." The activities organiser told us some people went to a weekly event at a local social club. We asked how it was decided who was going and they said, "I do, I decide who might benefit from it."

We asked if anyone had the opportunity to go out on their own rather than in a group, we gave the example about it being a lovely day and if someone wanted to go out would someone be able to take them. The activities organiser said one person went out independently but said "I could take them out if I had enough notice."

One person told us about how they had asked the activities organiser to take them out to buy a present. They told us "(activities organiser) told me what day I could go, (they) didn't ask me, then (they) came to take me on a different day. It was the day before my money comes in."

We asked was there any cost to people when they were going out. The activities organiser said they had three minibuses, one accommodated one person, another 3 people and the other 4 people. They said if one person was going out on their own they were charged 61p per mile, if it was more than one person this was divided up between people. We were concerned this system was unfair as some people would be paying more than others for transport.

On the first day of our inspection we observed a 'residents meeting' held by the activities organiser who joined the people already in the dining room. People had not been informed what time the meeting would take place and we did not see people given the choice of attending the meeting. Immediately after the meeting a person came into the room and started to play music, sing and demonstrate dancing and exercises. Again, people were not given the choice of whether they wanted to join in or if they were happy with the activity taking place where some people were still eating their breakfast. We saw one person, who was not able to move independently, was at the far end of the dining room throughout both activities without any interaction from staff.

The activities organiser gave us examples of some activities planned for the home. This included 'Ukulele Charlie coming to play for people and a group of people in their eighties coming to perform a concert. We found most of the activities were more suited to older people and lacked appeal to the younger people

living at the home.

People told us and the activities organiser confirmed there were no evening activities in the home. One person said, "Nothing to do in the evenings, I just go to bed".

We asked one person how the service learnt about their interests and supported them to maintain them. They said, "It took four months for (Activities organiser) to come and ask me what I would like to do. I am never invited to any activities. Sometimes I find out about them after they have taken place."

We asked two relatives about visiting. One said, "We can visit any time, they don't mind if I come during a meal." However, another said, "Families aren't really welcome." One person told us how much they would like their dog to visit them as hugging the dog helped their anxiety. They told us this was not allowed.

We found the provider had not complied with the Accessible Information Standard (AIS), which sets out a specific approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people with disabilities, impairment or sensory losses. We saw one person who experienced difficulty with verbal communication being asked by staff why they had pressed the call buzzer. The person made a sound which clearly indicated they needed the toilet. We spoke with the person later in the day and asked if they had been supported to try any technological communication aids. They said they hadn't but when we asked if they would like to, they nodded in a very determined manner. We asked if the person thought appropriate communication aids might help them to retain their dignity and independence. They again nodded determinedly. We later saw the person did have a pamphlet of communication symbols but struggled to use it due to physical issues. We asked the person if they were frustrated by their difficulty in communication and again they nodded in a very determined manner. We looked at the person's care file but could not find any evidence of the person having been supported to explore appropriate and effective communication aids.

We spoke with an advocate who told us they had suggested, over a year ago, an assessment at an 'Ace Centre' for the person they were visiting. Ace centres provide support for people with complex communications difficulties. We could not see any evidence of this being explored.

We concluded people were restricted in their lifestyle choices and were not supported in a person-centred manner.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Person centred care)

Information about how to make a complaint and the complaints procedure was available in the home. We saw complaints were managed in line with the policy. However, when one person expressed some concerns to us and we asked if they had spoken to the registered manager about them, they told us "(registered manager) is not approachable, need an appointment to see (them), not worth it, nothing would be done.

Inadequate

Is the service well-led?

Our findings

When we inspected White Windows in November 2017 we found not all necessary actions had been taken to make sure the service was compliant with regulations in relation to medicines management and risk assessment. We also found best practice in relation to managing DoLS authorisations was not consistently followed.

On this inspection we found the service remained in breach of regulation in relation to medicines management and risk assessment and identified a further breach of this regulation in relation to risks to people's health and welfare were not being managed. We found the service had not made any improvements in relation management of MCA and DoLS and were in breach of the related regulation. We also identified further breaches of regulations in relation to staffing, person centred care and privacy and dignity.

Although we saw systems were in place for auditing the quality and safety of the service, we concluded these were not robust or effective as they had failed to identify many of the shortfalls we identified during our inspection. Where auditing had identified issues, we saw actions had not been taken to address them. For example, we saw three audits completed by the regional manager, on behalf of the provider, had identified issues in relation to MCA assessments, completion of fluid charts and lack of appropriate activities. However, we found these issues had not been addressed.

We saw a 'manager monthly walk round audit' was based on CQC's five key questions of safe, effective, caring, responsive and well led but did not guide the auditor to check that equipment needed by people was available and did not look at issues in relation to people being able to access outside areas. The audit lacked any feedback from people who lived at the home or staff and we noted 64 of the 73 questions within the audit were answered with only a Y (yes) or N (No). The audit had not identified any of the issues we found and have detailed throughout this report.

Auditing had not identified the lack of accident and incident analysis and the provider had failed to take appropriate action in relation to areas of non-compliance identified by commissioners during their inspection in September 2018.This included assessment of people's capacity and completion of fluid balance charts.

The registered manager told us that opinions of people who used the service were sought through an annual 'Have your say' survey. However, when we asked to see the results of the most recent survey this was dated 2016.
This meant that auditing was not robust or effective and failed to include the opinions of people using the service.

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

The home had a registered manager. 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.

The registered manager was supported by a deputy manager, a regional manager and other members of the provider's management team.

People varied in their opinions of the registered manager. One person told us the registered manager was "not approachable, need an appointment to see (them)." Another person said the registered manager had "a poor attitude" and described to us how they felt they lacked respect for people living at the home. Their description was of such concern that we shared it with the regional manager for their consideration and action.

Another person told us, "I see her quite a lot, she is nice and approachable," and a relative said, "I don't see her very often, she is easy to talk to." Staff told us people who lived at the home rarely saw the registered manager or the regional manager.

We saw minutes of a number of meetings held within the home. These included nurses' meetings, general staff meetings, catering staff meetings and residents' meetings. The registered manager told us that governance meetings had recently been introduced.

A service improvement plan was in place. However, we saw areas including medicines management, capacity and auditing had all been noted as 'complete' when we identified issues in these areas.

The registered manager had notified the CQC of events within the service as required by regulation and we saw the rating from the last inspection was displayed in the home.