Discovery Care Limited

Fourwinds Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on 28 and 29 July 2016 and was unannounced.

Fourwinds Residential Care Home provides accommodation and personal care for up to 35 older people and people living with dementia. The service is a large converted property. Accommodation is arranged over two floors and a lift is available to assist people to get to the upper floor. The service has 31 single bedrooms and two double bedrooms that people could choose to share. There were 24 people living at the service at the time of our inspection.

A manager was leading the service. They had resigned and were working their notice at the time of our inspection. A registered manager had not been leading the service since May 2015. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the care and has the legal responsibility for meeting the requirements of the law. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider and manager did not have oversight of the service. They had not supported staff to provide a good level of care and staff were not all aware of their responsibilities. Checks on the quality of care being provided had been completed but the shortfalls in the service that we found at the inspection and not been identified. The provider said that a new manager had been appointed to lead the service but they had not followed their recruitment policy to make sure the new manager had the skills, competence, knowledge and experience to fulfil the role.

At the last inspection on 8 May 2015, we asked the provider to take action to make improvements to staffing levels, this action had not been completed. People's needs had been considered when deciding how many staff were required on each shift. However, the provider had not taken action to make sure sufficient staff, who knew people, were deployed to meet their needs. Robust arrangements were not in place for the safe management of the service when the manager was absent or on leave. Staff worked as a team to meet people's needs.

Safe recruitment procedures were not followed consistently. Staff had not completed health declarations stating they were physically and mentally fit to fulfil their role. Gaps in employment had not always been questioned. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Staff did not regularly meet with the manager to discuss their role and practice. Staff told us they did not feel supported and appreciated. They told us they were not confident to raise concerns with the provider. Staff had completed the training they needed to provide safe and effective care to people.

At the last inspection on 8 May 2015, we asked the provider to take action to make improvements to the management of risks to people; this action had not been completed. Action was not consistently taken to manage risks to people, including the risk of people developing pressure ulcers. Guidance for staff about how to manage risks had not always been followed. Some people's pressure relieving equipment was not used correctly and there was a risk that people would sustain skin damage because of this.

Assessments of people's needs had not been consistently completed to identify their needs. Detailed guidance had not been provided to staff about how to meet people's needs For example, how to care for a person with a catheter. No guidance had been provided to staff about how to provide one person's care. People were supported to have health checks such as eye tests.

People received the medicines they needed to keep them safe and well. However, medicines were not always stored safely or recorded accurately to keep people as safe as possible.

Plans were not in place to keep people safe in an emergency, including plans to evacuate people from the building. Following the inspection we raised our concerns about fire safety with the local Fire and Rescue Service. Risks associated with the building had not been assessed and action had not been taken to manage risk to people, including an open external balcony at the back of the property.

Although people and their relatives told us that staff were kind and caring, people were not always treated with respect. For example, meals for people who required a pureed diet was pureed together and people were not able to taste each separate flavour.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Applications had been made to the supervisory body for a DoLS authorisation when people who lacked capacity to consent were restricted.

Staff followed the principles of the Mental Capacity Act 2005 (MCA) and assumed people could make decisions. When people needed to make a specific decision their capacity to do so had not been assessed. Guidance was provided for staff about some the day to day decisions people were able to make. Decisions made in people's best interests had not been recorded to demonstrate how the decision had been made and by whom.

Accurate records were not maintained about the care and support people received. Information was not available to staff and health care professionals to help them identify any changes in people's needs. People's personal information was not always kept safe and some information was stored in communal records which may be accessible to other people and people not involved in their care.

People and staff told us some meal times were too close together and there was a long gap between supper in the evening and breakfast. Some items that people liked ran out regularly, such as yoghurts. The dining room was crowded and people did not always get the support they needed.

People and their representatives were confident to raise concerns and complaints they had about the service. However, some complaints had not been recorded so action had not been taken to check complaints and use them to continually improve the service.

People and their relatives were asked for their views each year. Many people did not return the survey they were sent. Action had not been taken to explore other methods of obtaining people's views and involving them in developing and improving the service. Staff did not have regular opportunities to share their

experiences of the service.

People told us they would like more to do. The activities person had left and people were not supported to participate in a range of activities.

Staff knew the signs of possible abuse and were confident to raise concerns they had with the manager or the local authority safeguarding team.

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.

You can see what action we told the provider to take at the back of the full version of the report.

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 to people had not always been identified and action had not been taken to reduce risks. Guidance had not been provided to staff about how to keep people safe in an emergency.

Staff had not been recruited safely, gaps in employment had not been checked and not all staff had completed a health declaration.

People were not always protected from the risks of unsafe medicines management.

The provider had not taken action to make sure there were enough staff who knew people, to meet their needs.

Staff knew how to keep people safe if they were at risk of abuse.

Is the service effective?

Requires Improvement

The service was not effective.

Staff did not have the opportunity to meet regularly with the manager to discuss their role, practice or any concerns they had. Staff had completed the training they needed to meet people's needs.

The times of meals had not been reviewed to make sure people were offered food regularly. Food was not always prepared to meet people's needs.

People were supported to see health care professionals when they needed to, have health checks and to attend healthcare appointments.

Staff followed the principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. Guidance had not been provided to staff about how to support people to make decisions.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with respect. For example, staff did not provide people the individual support they needed at meal times.

Staff did not have detailed information about people's likes, dislikes and preferences; or their life before they began to use the service. This would help staff get to know people and how they preferred their care provided.

People said that staff were kind and caring to them. People were given privacy.

Is the service responsive?

Requires Improvement

The service was not responsive.

Assessments of people's needs had not been completed. Detailed guidance had not been provided to staff about how to meet each person's needs.

People told us they wanted to take part in more activities at the service.

Systems were in place to resolve any concerns people had. However, complaints had not been analysed to develop the service. People and their relatives told us they were confident to raise any concerns they had with the staff.

Is the service well-led?

Inadequate

The service was not well-led.

A registered manager had not been working at the service for over a year. The manager had resigned. The provider had not taken action to make sure the new manager had the skills and experience they needed to lead the service.

Systems were not in place to make sure the service was adequately managed in the manager's absence. Staff did not have clear responsibilities and were not always held accountable.

Checks completed on the quality of the service were not effective. Action had not been taken to regularly obtain the views of people and their relatives. Staff did not have regular opportunities to share their experiences of the service.

Records about the care people received were not consistently accurate and there was a risk that action would not be taken to provide the care people needed	

Fourwinds Residential Care 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.

This inspection took place on 28 and 29 July 2016 and was unannounced. The inspection team consisted of two inspectors 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.

Before the inspection we reviewed the Provider Information Record (PIR) and previous inspection reports. The PIR is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications we had received from the service. Notifications are information we receive from the service when significant events happen, like a serious injury. We spoke to a clinical nurse specialist for older people who had given the manager guidance about how to improve areas of the service.

During our inspection we spoke with nine people living at the service, six visiting friends and relatives, the provider, manager, a visiting health care professional and staff. We visited some people's bedrooms, with their permission; we looked at care records and associated risk assessments for five people. We looked at management records including staff recruitment, training and support records, health and safety checks for the building, and staff meeting minutes. We observed the care and support people received. We looked at their medicines records and observed people receiving their medicines.

We asked the provider to send us their maintenance plan for the premises and improvement plan for the service. They sent us their maintenance plan and a staff development plan
We last inspected Four winds Residential Care Home in May 2015 and rated the service Requires

Improvement overall. We found that the provider was in breach of two regulations and told them to take action to make improvements.

Inadequate

Is the service safe?

Our findings

At our last inspection we found that the provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to keep people safe and meet their needs. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We checked the action the provider had taken to make sure people were supported by sufficient staff at all times.

People, their families and friends told us, "There are not enough staff here, they are rushed off their feet", "There are shortages of staff", "I think there could be a few more staff" and "Sometimes staffing is a bit thin on the ground". People told us the length of time it took staff to respond to their call bell, "Depends on how busy they are". Staff told us there were often not enough staff on duty to provide the care people needed. One staff member said, "I feel really bad about not spending time with people. We can't care as much as we would like when there only three of us". The manager told us staff did not have time to do "some things" including chatting to people when staffing levels were reduced.

The manager said she worked out the required staffing levels based on people's needs and four care staff were needed during the day to give people the support they needed. They told us they had some staff vacancies. Staff told us they covered as many vacant shifts as they could and they felt "exhausted" at times. Some vacant shifts had not been covered and people's care had been provided by three care staff instead of the required four. The manager told us this was not enough and at these times she stepped in to help. On the first day of our inspection there were three care staff on duty and a new apprentice was shadowing experienced staff. The manager contacted a staff member and they come in to work at the service.

Staff told us that they were not able to provide some care people needed when staffing levels were reduced, such as supporting people to have baths or showers. Some people who needed two staff to support them had not had a bath for several weeks.

Most people spent their time in the lounge. The manager told us there was always a staff member present in the lounge area so they were available if people needed support. We observed times when this did not happen and people were not checked for long periods of time. Some people were at risk of falling. We observed one person walking round the lounge without their walking aids and another person slide to the edge of their chair on several occasions. We alerted staff to this.

Staff told us that an activities coordinator was usually in the lounge with people during the day. However, the activities coordinator had left and the manager told us this post was vacant. Action had not been taken to deploy a staff member to be available if people needed support.

The provider had failed to deploy sufficient numbers of staff to make sure that people's care needs could be met. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives we spoke with told us they felt safe at the service. However, our findings did not agree with the feedback we received.

Risks to peoples' skin health, such as the risk of development of pressure ulcers, had not been assessed consistently. Two people had pressure ulcers which were being treated by the community nurse. Pressure relieving equipment was available to people who needed it, however this was not always used correctly. One person's pressure relieving mattress was set for a person who weighed 90kg, staff were unable to weigh the person and did not know how much they weighed. The person appeared to weigh less than 90kg. We asked the manager how they knew the correct setting for the pressure relieving equipment. They replied, "I've never been shown how to work it out".

Another person was sitting on pressure relieving cushion. We looked at the pump to check it was working correctly. The low pressure alarm light was on. We asked staff if they checked the pumps before people used the equipment to make sure it was operating correctly and they said they did not. Using a pressure relieving mattress or cushion that if too firm or soft may not give people the best protection from developing skin damage.

Moving and handling risk assessments had been completed and guidance was provided to staff about how to move people safely. However, one person told us "When I am hoisted, usually there are two of them, but very occasionally there is only one, but we manage". Moving and handling risk assessments stated that two staff were required to safely support people to move using a hoist.

Accidents and incidents were recorded by staff. The manager assessed these looking at the times, place and circumstances to identify any pattern and took action to reduce risks to people. For example, for one person the manager recently noticed a pattern of falls at night time. An alarmed mat was placed next to the person's bed to alert staff when the person got out of bed. The manager said they hoped this would reduce the risks of the person falling. One person had suffered lots of small skin tears; these were not recorded as accidents. Action had not been taken to find out how the person was damaging their skin and take action to help the person keep their skin as healthy as possible.

At our last inspection we found that there were not enough call bells in the lounge and visiting professionals asked the provider to make sure people were able to call for assistance when they needed it. People did not have access to call bells in the lounge and were still not able not raise the alarm if an accident happened.

The fire evacuation plan talked of 'progressive evacuation' which contradicted people's individual emergency evacuation plans. There was no separate evacuation plan for night time when there were less staff on duty. Evacuation equipment was not available to evacuate people safely and staff were not able to tell us how they would safely evacuate people from the building. The manager said that regular fire drills were held to practice evacuating the building. The last recorded fire drill was in August 2012, the manager told us that a drill had been held since then but could not locate the record. Fire exits were clearly marked but a number of fire doors, including doors to people's bedrooms were propped open and would not close if the fire alarm went off. Regular tests were carried out on extinguishers, emergency lighting and fire doors. Following our inspection we informed the local Fire and Rescue Service about our concerns.

Parts of the service posed a risk to people including an external balcony. There was a view of the sea from the balcony and some visitors used the balcony to meet with their loved ones. People and staff who smoked also used the balcony. The fence around the balcony was low enough to climb over and there was a drop as the balcony was higher than ground level. Two low wooden gates led from the balcony, down a slope to the road. The gates had a pull across bolt lock that was not difficult to unlock. There had been an incident when

a person had left the service on their own at night. The manager said that they had not assessed the potential risks to people from the open balcony. The manager said they had asked the provider several times to have two cracked windows repaired. The windows were still broken. The provider sent us a copy of their maintenance plan, window repairs were not included in the plan.

The electrical wiring certificate had expired and a company had carried out a new check of the electrical wiring. A new safety certificate could not been issued as some work was needed to ensure the electrical wiring was safe. This work had not been carried out.

The provider had failed to consistently assess the risks to people's health and safety and take action to manage risks. They had failed to do all that was reasonably practicable to mitigate the risks to people and ensure that the premises were safe and was used in a safe way. The provider had failed to respond to and manage risks associated with major incidents and emergency situations. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from the risks of unsafe medicines management. Medicines were not stored at the correct temperature. The temperature in the medicines storage room was consistently recorded as between 26°C and 31°C. Guidance on the room temperature record chart stated 'Normal temperature range 25°C'. Some medicines stored in the room needed to be stored below 25°C so they would remain effective and safe to use. A fan was being used in the room to reduce the temperature but this was not effective.

Other medicines were stored in a fridge, the maximum and minimum temperature of the fridge was not monitored. The fridge temperature was 13°C which is outside the normal range of 2°C to 8°C recommended by the Royal Pharmaceutical Society of Great Britain. Action had not been taken to monitor and reduce the temperatures that medicines were stored at and there was a risk that high temperatures would reduce the effectiveness of people's medicines.

The providers 'Medication (Administration)' policy was not followed and medicines were not always stored securely. The manager told us that the door to the medicines room was left open at night to reduce the temperature in the room. Medicines that were no longer needed were stored in the room before being sent for destruction and were not locked away. People, staff and visitors to the service had access to the medicines stored in the room. Many people walked around the home without the support or supervision of staff. Staff told us that one person was often up all night walking round the service. High risk medicines were stored securely.

Effective processes were not in operation to manage high risk medicines. Some high risk medicines were stored correctly but records of them had not been kept and action had not been taken to check the stock levels were correct. These medicines had not been sent for destruction when they were no longer needed and remained at the service. Medicines that are surplus, unwanted or expired should be disposed of promptly as there is a risk they could get mixed up and accidentally be given to people.

Bottles of liquid medicines including eye drops must be used within a certain time after opening. Some eye drops which were in use did not show a date of opening. This was important to ensure medicines were used safely within a given shelf life.

We looked at people's medicines administration records (MARs) and other records used to monitor the administration of medicines. Some entries on people's MARs had been handwritten. These had not been checked by a second person to reduce the risk of mistakes. Staff should sign the MAR after they had

administered a person's medicine and checked they had taken it. One person's MAR record had not been signed to show they had taken their medicines. An unsigned MAR may indicate to other staff that a person may not have had their medicine. Effective checks had not been made on records to identify any concerns that may put people at risk.

The provider's 'Medication (Administration)' policy did not provide clear guidance to staff about how to support people to manage their own medicines. One person administered all their medicines. The person's risk assessment instructed staff to monitor their medicines daily and review the risk assessment six monthly. Staff checked their medicine stock every four weeks. They did not check if the person was taking their medicines safely every day. There was a risk that any mistakes the person made when taking their medicine would not be identified quickly to keep them as healthy as possible. The person told us they dropped their tablets at times and asked staff to find them, they said one had not been found. Risks associated with the person dropping their medicines had not been identified and strategies had not been agreed with the person to minimise the risk.

We observed people receiving their medicines. This was not always done in a safe way. The manager told us that they had a 'hands off' policy and staff should not touch people's medicines. We observed one staff member put a tablet into a person's mouth with their fingers. The staff member did not wash their hands before getting the person's medicine or use a spoon or 'medicines pot' to help the person take the medicine.

The provider had failed to operate proper and safe medicines management processes in relation to the ordering, storage, disposal and recording of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Potential staff completed an application form and references were requested. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Providers are required to check their staff's health status before they are employed in case they need to make any reasonable adjustments. We checked information relating to three staff and none had completed a health questionnaire to enable the provider to give consideration to any adjustments. One staff member had only one written reference and two staff had gaps in their employment history of several years that had not been questioned.

The provider had failed to operate effective recruitment procedures to make sure staff were of good character and had the experience necessary for the work they perform. The provider had failed to ensure staff are able to properly perform tasks intrinsic to their role, by reason of their health, after reasonable adjustments have been made. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew people well and were able to recognise signs through behaviours and body language, if people were upset or unhappy. One person appeared to be upset; staff noticed this and sat with the person, gave them a tissue and stroked their hand. The person appeared to be comforted by this.

Staff explained how they would recognise and report abuse. Staff knew about the different types of abuse and had received training on keeping people safe. They told us they were confident that any concerns they raised would be taken seriously and fully investigated to ensure people were protected. Staff were aware of the whistle blowing policy and knew how to take concerns to agencies outside of the service if they felt they were not being dealt with properly. The manager was aware of her responsibilities to safeguard people from

harm and had raised any concerns to the local safeguarding team.

Requires Improvement

Is the service effective?

Our findings

People told us the food at the service was satisfactory. Their comments included, "The meals are OK", "Normally the food's OK, but they don't do the onions very well" and "I think the food's OK, but it's not entirely what I'm used to".

Meal times were busy, there was one dining room for people to use, some people chose to eat in their bedrooms. The dining room was crowded and people had to wait for the support they needed. There was a long delay between some people who were sitting next to each other together being served their meal. Some people were asking for their meals, one person walked away from the table. At one point meals were brought into the room on a trolley and people commented that their meal had arrived. The trolley was then removed before people were served. One person asked staff several times during their meal if they could go to the toilet. Staff told them, "Not just yet, eat a bit more" and "After your pudding". The person ate their meal quickly and went directly to the toilet when they had finished. Staff did not support the person to go to the toilet when they requested and there was a risk that they did not eat as much as they wanted because they needed to go to the toilet.

We observed staff leaning over people to support other people; this made some people duck their heads and interrupted their meal. Staff took one person's meal away from them to cut their food up without telling the person what they were doing. The person looked worried when they meal was removed.

Meals were not consistently prepared to meet people's needs and preferences. Some people who had difficulty swallowing or were at risk of choking were offered soft or pureed food. Foods were pureed together and were not presented separately in an appetising way. People were unable to taste the separate flavours of each food. One person told us they were at risk of choking on their food and had to be careful about what they ate. The person had meat pie for lunch, they told us they could not eat the pastry because it made them cough. They had seen the Speech and Language Therapy (SALT) team who recommended they did eat certain foods including bread with crusts. The manager and cook did not know about the recommendations and the person was often served sandwiches with crusts at tea time. Food was prepared to meet other people's needs including diabetics and people who needed extra calories.

One person told us, "The meals are a bit close together". One person's relative told us, "There is not enough to drink, especially in the afternoon". A large two course lunch was served at 12 noon and tea was served at 4:00pm. People were offered a drink and a snack at 3:00pm. The cook told us people "Barely eat any tea" and the manager said, "People are not ready for tea at 4:00pm". Supper was served at 7:00pm and breakfast at 8:00am. Action had not been taken to review the meal times and act on people's feedback.

One person asked the cook for a yoghurt on the first day of our inspection. The cook told them, "We haven't got any at the moment. They will be in tomorrow". The cook and the manager told us that several people liked to eat yoghurts during the day, and they often ran out as the provider did not purchase the number ordered by the cook. The manager said they used the petty cash to 'top up' food supplies each week including cakes and yoghurts, however people could not always have the foods they like when they

requested them. People were offered a choice of two meals and alternatives were prepared at their request.

The provider had failed to ensure food was prepared and available to meet each person's needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us they thought staff had the skills they needed. Their comments included, "I feel the staff are well trained" and "From what I see, they (staff) seem qualified".

The manager had introduced more face to face training to complement the existing workbook and DVD training. There were two courses booked every month this year which included basic training and subjects related to people's specific needs including nutrition and hydration.

Staff completed training about medicines management; however their practice was not always safe. The supplying pharmacist completed a competency check on each staff member when they finished their training. The manager had not completed further checks to make sure staff's practice remained safe and action had not been taken improve staff's practice.

Staff had attended practical 'moving people' training. We observed two staff moving a person using a hoist and sling. They reassured the person as they looked worried and took their time and made sure the person was comfortable. One staff member asked the person to hold onto the bars of the hoist that held the sling, the other staff said they thought the person should cross their arms across their chest and not hold on. No guidance had been provided to staff about how to move the person safely with the hoist and staff practice was not consistent.

Staff were knowledgeable about people's varying needs and health conditions. All staff had either completed or were working towards a vocational qualification in care. One staff member told us they had 'done a lot of courses' and said they found a recent course about dementia very useful. They told us about different types of dementia and said "Since then I now recognise different signs in people here and now know it is related to their type of dementia."

Staff attended daily handover meetings at shift change so they were up to date about everyone. The manager told us that they were not meeting with staff on a one to one basis (supervision) as frequently as they should be. They said this was due to them having to cover some shifts, but now some new staff had been recruited they planned to organise one to one meetings for all staff before they left.

The provider had failed to make sure staff received appropriate support and supervision to enable them to carry out the duties they are required to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care was planned to keep people as healthy as possible. One person told us, "If I am ill, I can see the doctor". Another person said, "When I was not well six months ago, they got the doctor in quickly and they took me to hospital. The manager went to hospital with me". People told us they saw the chiropodist regularly.

A visiting health care professional told us that staff contacted people's doctors without delay if they had concerns about people's health and followed their advice and guidance and gave them the information about people they needed to make decisions. They told us that staff asked them for advice about people when they visited. People were supported to have regular health checks, including eye tests.

Two staff had completed diabetes training and were qualified to check people's blood sugar levels. The health care professional told us this had highlighted when changes were needed to people's medicines. The manager and two staff had completed training to take basic observations of people's health so they could share this with people's doctors before they visited.

People were supported by staff or people who knew them well to attend health care appointments, including outpatient appointments. This was to support them to tell their health care professional about their health and medicines and to make sure that any recommendations were acted on when they returned to the service.

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 be as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

The manager told us that most people were not able to make complex decisions about their care and treatment. Some people needed to make complex decisions including consenting to the use of bedrails. Assessments of people's capacity to make complex decisions had not been completed, including decisions about the use of bedrails. Some decisions had been made in people's best interests by people who knew them well when the manager thought people did not have the capacity to make the decision. Records of how had made the decision and how had not been kept.

People's capacity to make 'less complex' day to day decisions had not been assessed; however, staff assumed people had capacity to make less complex decisions. Guidance had not been provided to staff about what decisions people were able to make and the support that staff should provide to help people to make straightforward decisions. Staff told us everyone living at the service was able to make straightforward decisions, such as what they wanted to drink and how they shared these with staff. Most staff had received training in relation to the MCA or were booked to attend a course.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The manager was aware their responsibilities under DoLS. Applications had been made to the local authority for standard DoLS authorisations to deprive some people living at the service of their liberty. At the time of our inspection three people was the subject of a DoLS authorisation and others were waiting to be assessed by their local authority. People moved freely around the building without restrictions. Guidance was available to staff in the office about the action to take if someone with a DoLS authorisation passed away at the service.

Requires Improvement

Is the service caring?

Our findings

People and their relatives we spoke with told us staff were caring, their comments included: "All the staff are friendly. They treat me like family", "I like the girls working here", "The staff are lovely. They are very kind" and "They do their very best".

Staff did not always treat people with respect or talk to them in a respectful way. Some people needed support at mealtimes. One staff member sat between two people who needed help and supported them both at the same time. Another staff member assisted two people sitting on opposite sides of the room. The staff member walked from one person to the other and stood over them while helping them. People did not get the time or attention they needed.

We observed one person slip down in their chair in the lounge several times. Staff told us the person did this "for attention". One staff member told the person, "Pack this up please [person's name]. You will put yourself on the floor". Staff did not ask the person if they wanted anything or spend any time with them. Staff moved another person using a hoist. The person looked very worried, staff did not offer the person reassurance.

Personal, confidential information about people and their needs was not kept consistently safe and secure. Some information about people was stored in communal records and not their personal records, such as their weight and when they had a bath or shower. There was a risk that unauthorised people would have access to people's personal information.

People appeared relaxed in each other's company and some people spent time chatting to their friends. Most staff showed genuine affection for people and people responded in a similar way. One person told us, "I do not have a bad word to say about the staff. They do their very best".

A limited amount of information was available to staff about people's life history, for example, about their career. This information helps staff get to know people and provide their care in the way they prefer. People and their families had been asked to share some information before they moved into the service but for some people the information was limited. Action had not been taken to make sure staff had as much information about people as possible.

Detailed information about people's preferences, likes and dislikes was not available for staff. Some people's care plans contained basic information such as 'Prefers bath to shower'. Information about people who had recently moved into the service was very limited. Some people were able to chat to staff and tell them how they liked their care provided, most people were not. Staff relied on information shared with them by other staff and their own observations and there was a risk that people may not be supported in the way they preferred.

Guidance was not provided to staff about how to share information with people, such as showing them items. Some people were living with dementia and found it difficult to understand what staff were telling them. Ways of supporting people to understand had not been considered, such as using pictures, signs or

objects. There was a risk that information would not be provided to people in a way that they understood. Information was provided about aids people used such as glasses or hearing aids. One person's care plans stated; 'Hear well and wears glasses for reading'. The person was wearing their glasses to read the newspaper.

People told us staff usually responded quickly when they needed support. Their comments included, "Generally, staff respond to my call bell reasonably", "When I use my call bell, they usually come quickly" and "At night time, if I ring, they are here in no time". People's friends and relatives were able to visit whenever they wanted. They told us they visited regularly and were made to feel welcome.

Staff supported people to choose where they spent their time, some people preferred their own company and stayed in their bedrooms, other people spent time in the lounge. One person told us, "I like to stay in my room". People who could, walked freely about the service and went back to their bedroom when they wanted to. People told us, "If I want to go to my room I can" and "I am free to walk around, but using a frame".

People told us they had privacy. One person told us "Staff knock when coming into my room". Staff offered people assistance discreetly without being intrusive. Staff made sure that doors and curtains were closed and people were covered when they provided their personal care. Another person said, "They are bright staff, they keep things to themselves. They do not talk about me in front of people; they keep things privately which is good".

Staff told us at the time of the inspection that people who needed support were supported by their families, solicitor or their care manager, and no one had needed to access any advocacy services.

Requires Improvement

Is the service responsive?

Our findings

The manager had reviewed and rewritten everyone's care plan since they began working at the service. People's relatives told us they had been involved in planning people's care. Their comments included, "We drew up my relative's care plan when they came. There was a review recently, they altered a couple of things for us and we signed it off" and "My relative has a care plan and a recent review was signed off by me".

Most people were able to tell staff how they liked their care provided however their preferences were not recorded. Staff told us that they did not refer to people's care plans for information about the care and support they needed and relied on people telling them, information from other staff and on their own experience.

One person's care plan instructed staff to support the person to sit on a pressure relieving cushion. The person did not use the cushion during our inspection. Staff told us the person often refused to sit in the chair with the cushion on and preferred to sit with their friends. Staff had not considered moving the cushion so the person could sit safely where they preferred.

Before people were offered a service, an assessment of their needs was completed with them and their relatives, to make sure the staff could provide the care they required. Further detailed assessments had not been completed when people began using the service to follow up on needs identified in the pre-admission assessment. One person had moved into the service shortly before our inspection. An assessment of their needs had been completed however further assessments of their needs, including their risk of falling and nutritional needs had not been completed. A care plan, including guidance to staff about how to provide the care and treatment the person needed, in the way they preferred, had not been written. The person was at risk of not receiving consistent and effective care and treatment as their care needs had not been recorded for staff to use as a guide.

Assessments of other people's needs had not been consistently completed to identify the care they needed. One person used pressure relieving equipment. The manager told us they did not know why the person used the equipment or if it was still required to keep their skin healthy. An assessment of the person's skin had not been completed.

People's care plans did not contain detailed guidance to staff about how to support people. For example, guidance had not been provided to staff about how to manage people's catheters, including signs that it was blocked, how to keep it clean and how often the bags needed to be changed. There was a risk that people's catheters would not be cared for correctly to keep them healthy and reduce the risk of infection.

People's moving and handling care plans did not contain guidance to staff about how to move people safely considering regular changes in their needs. For example, one person's care plan stated 'Sometimes capable of transferring from/to commode/toilet from wheelchair with a walking frame but at other times needs hoisting. Assess mobility before carrying our all transfer'. Guidance had not been provided to staff about how assess the person's mobility. There was a risk that people may not always be moved safely.

Some areas of people's care plans included detailed guidance to staff about how to identify changes in their needs quickly and the action to take. Such as the normal blood sugar levels for a person with diabetes and the action staff needed to take if it fell below a specific level.

The provider had failed to consistently assess people's needs and plan their care with them, with a view to achieving peoples' preferences and ensuring their needs were met. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not offered a range of activities to do during the day. People and their relatives told us, "There was enough for me to get interested in. We did have a person who did activities with us, they have left", "A bit more activities could be done" and "My relative does like activities and misses not doing them". We observed people sitting in the lounge for several hours each day with a television playing loudly. People told us they were not watching the television. People who wanted to go out were not supported to do this. Staff told us one person "Loves to go out, but there aren't enough staff to take them".

People told us their spiritual needs were met at the service. Their comments included, "The Vicar does visit and we have a Communion service", "I have Communion every week" and "My relative gets visits from the Catholic Priest".

A process to receive and respond to complaints was in place. Information about how to make a complaint was available but action had not been taken to make sure people were aware of it and it was meaningful to everyone, such as using large print or pictures. The manager told us people and their families had made complaints and raised concerns about the service. People's complaints and the action taken to investigate and resolve them had not been recorded. Checks could not be made to make sure that complaints received were dealt with and used to improve the service. People and their relatives told us they were confident to raise any concerns they had with the manager.

Inadequate

Is the service well-led?

Our findings

The manager had been managing the service for nine months and was working their notice at the time of the inspection. Some staff told us they did not feel valued or appreciated by the manager and provider and were demotivated. One staff member told us, 'The provider doesn't speak to staff or even acknowledge them when he visits the service". Another staff member said, "I often feel blamed rather than supported" and "I find the manager scary at times".

Staff told us the manager had delegated lots of tasks to them, such as contacting people's doctors and community nurses, and this reduced the amount of time they were available to provide people's care. They told us they often felt under pressure or rushed, especially when staffing levels were reduced. Staff did not feel confident to ask the manager for support to prioritise their workload. They told us on occasions they did two jobs at once, such as supporting people in the lounge, while ordering the monthly supply of medicines. This increased the risk of errors and mistakes being made.

Staff were not fully aware of their specific roles and responsibilities and could not been held accountable for the service they provided. When the manager delegated tasks she did not make sure staff knew and understood what they were responsible for. For example, senior care staff who administered medicines told us it was the cleaner's responsibility to keep the medicines room clean. The manager told us it was the senior care staff's responsibility to clean the room. No one had taken responsibility for the task and the room and sink were dirty.

Systems were not in place to support the manager and delegate some of the responsibility for managing the service, such as providing out of hours support to staff and completing administration tasks. When the manager was on leave no one was responsible for overseeing the management of the service. The provider "popped in" and the registered manager from another service telephoned staff.

The provider and manager did not have a clear vision of the quality of service they required staff to provide and how this would be delivered. They were not aware of the impact that reduced staff numbers had had on the quality of care people received. Values including dignity and respect did not always underpin the service provided to people each day. Staff told us they wanted to provide a high quality service too people but were not supported to do this. One staff member told us, "The staff are committed to the people who live here, they would do anything for them". Some staff told us they would not want a member of their family live at Fourwinds.

Care staff worked together as a team to provide care to people. One staff member told us, "I haven't worked here long but I feel part of the team". Staff were not given feedback about their performance to develop their skills and make them feel valued as there was lack of staff meetings and one to one meetings.

People and their families were asked for their views and opinions about the service yearly. A quality assurance survey was sent to people and their relatives and some responses had been received. The feedback received was not collated to look for patterns and trends and feedback was not provided to

people and their relatives about any action taken to improve the service. The manager told us that some people were not able to complete a questionnaire. Other ways of obtaining their views had not been tried to make sure that everyone's views were heard.

The manager told us they no longer held residents and relatives meetings as they had not been well attended. They told us people and their relatives could pop in to her office and speak to her if they wanted to. One person told us, "We had a resident's meeting at Christmas time. We asked for scampi, but we have not had it yet". Action had not been taken to regularly involve people and their family and friends in developing and improving the service.

Staff did not have regular opportunities to share their views about the quality of the service and make suggestions about changes and developments. The manager told us staff had the opportunity to give feedback about the service during their supervision meetings but staff did not receive supervision regularly. Staff meetings were not held regularly and notes of what had been discussed were not available for staff to refer to if they were not able to attend the meeting.

The provider and manager did not have oversight of the service. They had not completed checks on all areas of the service to make sure that it was of a good standard. Checks that had been completed, including medicines management audits were not effective and the provider and manager had not identified the shortfalls we found at the service.

The manager and provider did not consistently monitor and challenge staff practice to make sure people received a good standard of care. The registered manager told us the checks they completed were not recorded, so the development of the service could not be monitored. The provider had not completed regular checks on the quality of the service.

The manager visited the service unannounced at night once a month. They checked that people were receiving the care they needed and staff were performing their duties. Records of these visits were kept.

The provider had failed to assess, monitor and improve the quality and safety of the service provided to people. They had failed to seek and act on feedback from relevant people, including service users, on the services provided to continually evaluate and improve the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records in respect of each person's care and support had been kept. At our last inspection we found that records were not always maintained accurately. Action had not been taken to make sure that records kept were accurate and complete. Staff told us they often did not have time to complete records to record the care and support people received. Records did not contain all the information staff and visiting health care professionals needed to assess, review and plan people's care, such as what they had eaten and drunk. Inaccurate records could put people at risk of not receiving the care they needed quickly.

The provider had failed to maintain an accurate, complete and contemporaneous record in respect of each person, including a record of the care provided to them and of decisions taken in relation to the care and treatment provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had informed staff that Care Quality Commission (CQC) would complete an unannounced inspection of the service and would speak to staff. Staff had been encouraged to be open when speaking to inspectors. Staff had also been reminded to read and follow people's care plans.

The provider told us on their Provider Information Record that a registered manager had not been working at the service since May 2015. The manager had been working at the service since October 2015 and had submitted an application to become the registered manager. They did not complete the application correctly and it was returned to them. The manager and provider had not taken action to check the status of the application and make sure a correct and completed application was submitted. The provider told us they had appointed a new manager to replace the current manager. They told us the new manager had not managed a care home service before. They had not followed their recruitment policy to check that the manager was of good character, was able to properly perform tasks intrinsic to their role and had the necessary qualifications, competence, skills and experience to manage the service.

The provider had failed to comply with a condition we had applied to their registration requiring them to ensure that the service is managed by an individual who is registered as a manager. This is a breach of Section 33 of the Health and Social Care Act 2008.

Registered providers are required to display the most recent rating of their performance by the CQC at the service and on any websites maintained for or by them. The provider had not ensured that the most recent rating was displayed at Fourwinds Residential Care Home. We reminded the provider to display the rating several times during the inspection and they did this. We gave the provider five days to display their rating on their website. We checked that they had done this and found that they had not.

The provider had failed to display the most recent rating of their performance by the Care Quality Commission on websites maintained for or by them. This is a breach of Regulation 20a of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Section 33 HSCA Failure to comply with a condition The provider had failed to comply with a condition we had applied to their registration requiring them to ensure that the service is managed by an individual who is registered as a manager. This is a breach of Section 33 of the Health and Social Care Act 2008.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to consistently assess people's needs and plan their care with them, with a view to achieving peoples' preferences and ensuring their needs were met. The provider had failed to ensure food was prepared and available to meet each person's needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to operate proper and safe medicines management processes in relation to the ordering, storage, disposal and recording of medicines. The provider had failed to consistently assess the risks to people's health and safety and take action to manage risks. They had failed to do all that was reasonably practicable to mitigate the

risks to people and ensure that the premises were safe and was used in a safe way. The provider had failed to respond to and manage risks associated

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to operate effective recruitment procedures to make sure staff were of good character and had the experience necessary for the work they perform. The provider had failed to ensure staff are able to properly perform tasks intrinsic to their role, by reason of their health, after reasonable adjustments have been made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had failed to display the most recent rating of their performance by the Care Quality Commission on websites maintained for or by them.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to maintain an accurate, complete and contemporaneous record in respect of each person, including a record of the care provided to them and of decisions taken in relation to the care and treatment provided. The provider had failed to assess, monitor and improve the quality and safety of the service provided to people. They had failed to seek and act on feedback from relevant people, including service users, on the services provided to continually evaluate and improve the

The enforcement action we took:

We served a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy sufficient numbers of staff to make sure that people's care needs could be met. The provider had failed to make sure staff received appropriate support and supervision to enable them to carry out the duties they are required to perform.

The enforcement action we took:

We served a warning notice.