Farrington Care Homes Limited

Wainford House 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

Wainford House is a care home providing care and support to a maximum of 28 older people, some of whom were living with dementia. At the time of our visit there were 27 people using the service. The inspection was unannounced and took place on 16 February 2016.

We carried out an unannounced comprehensive inspection of this service on 12th October 2015. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this comprehensive inspection to check that they had followed their plan and to confirm that they now met legal requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Wainford House on our website at www.cqc.org.uk.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

•□Ensure that providers found to be providing inadequate care significantly improve.

•□Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

•□Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

•□Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

The home had a registered manager in place. 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 requirements in the Health and Social Care Act 2008 and associated regulations about the service is run.

People told us they felt safe living in the service. However, people were put at risk of harm because care records and assessments did not reflect current areas of risk and how these should be managed to protect the person from harm.

Medicines were not consistently managed and administered safely.

People told us, and we observed, that there were not always enough staff available to meet people's physical and emotional needs. The manager had not made improvements to the staffing levels.

The manager and provider had not taken action to ensure the competency of staff following our previous inspection where we identified that the training staff had received was ineffective and did not provide them with the knowledge they required for the role. Staff did not receive the appropriate support from the management of the service to develop in their role.

Improvements had been made to ensure that appropriate Deprivation of Liberty Safeguards referrals had been made where required, and assessments of people's capacity had been completed where appropriate. However, staff remained confused and unsure about the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards.

People were not consistently supported to live full and active lives, and to engage in meaningful activity within the service.

Care planning for people did not reflect their current needs and the information was generic. There were limited life histories for people living with dementia, and care records were not personalised to include people's hobbies, interests, likes and dislikes. Some work had been undertaken to improve these following our inspection, but they remained unfit for purpose.

People told us they were not consistently involved in the planning of their care. Improvements were required with regard to how people are involved in the planning of their support in the future, and how their views are reflected in their care records.

There were no adequate systems in use to monitor the quality of the service and to identify shortfalls and areas for improvement. There wasn't an open culture at the service. There was no process in place to gain the feedback or views of staff, and discussions had not been held with staff following our previous inspection.

There was a complaints procedure in place and people told us that they knew how to complain.

There was a recruitment procedure in place to ensure that prospective staff members had the skills, qualifications and background to support people.

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 and we found that action had not been taken to improve safety.

Medicines were not managed or administered safely.

There were not enough staff available to meet people's needs.

Risks to people were not managed and minimised effectively.

Is the service effective?

Requires Improvement

The service was not consistently effective and action had not been taken to improve its effectiveness.

The training staff received was not effective in providing them with the knowledge and skills they required to deliver safe and appropriate care. There was no system for assessing staff competency.

The service was not complying with the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) because staff understanding and practice was poor.

People had a choice of suitable and nutritious meals. However, people did not always receive the support they required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We found that some action had been taken since our last inspection to ensure staff responded to people in a more caring and kind manner.

We observed that staff interacted with people in a caring way, however, interaction with people was often task focussed and not individualised.

Is the service responsive?

Requires Improvement

The service was not consistently responsive and we found that action had not been taken to improve this area of the service.

People did not receive support which was planned and delivered in line with their personalised care plans. People were not consistently involved in the planning of their care and support.

People did not have access to meaningful activity and stimulation.

People told us they knew how to make complaints about the service.

Is the service well-led?

Inadequate

The service was not well-led and we found that action had not been taken to improve the governance systems in place.

Robust governance systems capable of identifying shortfalls were not in place.

The culture in the service was not open and transparent. Staff were not involved in discussions about service improvement.

Action had not been taken to make the significant improvements required following our previous inspection in October 2015.

The provider was failing to accurately reflect the quality of the service provided on their website their website.

Wainford House Residential Care Home

Detailed findings

Background to this inspection

We undertook an unannounced comprehensive inspection of Wainford House on 16th February 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 12 October 2015 inspection had been made. The team inspected the service against all of the five questions we ask about services: is the service safe, is the service effective, is the service caring, Is the service responsive, and is the service well-led? This is because the service was not meeting some legal requirements.

The inspection was undertaken by two inspectors and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During our inspection we spoke with 11 people who used the service, three members of staff and the registered manager. We looked at the care records for eight people, including their care plans and risk assessments. We looked at four staff recruitment files, medicine administration records, minutes of meetings and documents relating to the quality monitoring of the service.

Before the inspection we examined previous inspection records and notifications we had received. A notification is information about important events which the service is required to tell us about by law.

Inadequate

Is the service safe?

Our findings

At our last inspection on 12 October 2015 we identified breaches of regulation relating to concerns about how the service kept people safe and how they ensured there were enough staff. Some people were not receiving the care and support they required in order for their health, safety and welfare needs to be met. The service was not identifying and acting upon risks to protect people from harm and there were not enough staff to meet people's needs. We were so concerned that we met with the provider's representatives to discuss their action plan to make improvements. This inspection was completed to check progress against the action plan. However we found that little progress had been made and the manager confirmed that they would not be making their own timescale for improvements.

Care planning that had been put in place for people still did not consistently reflect people's current and changing needs. For example, the registered manager told us about one person's repeated infections, but there was no information about how staff were safely supporting the person with this in their care records. Staff we asked were not aware of the persons repeated infections or that they were required to monitor the person to ensure future infections could be identified quickly. New diabetic care plans had been put in place for people living with diabetes. However, these did not provide staff with sufficient detail as to what action they were expected to take to support people living with diabetes in a safe way. For example, one person's plan stated staff should test their blood sugar. However, it didn't state how often, nor what blood sugar ranges were safe for this person. Staff we spoke with also couldn't tell us this information, so there was a risk they would not recognise if action needed to be taken. Another person's diabetic care plan stated that staff should call for medical assistance if they became 'concerned'. However, it didn't state what signs the person may display if they were becoming unwell with their diabetes, or what symptoms might lead staff to become concerned. Staff couldn't tell us this information which meant we were concerned about the quality of diabetes care available for those people.

Action was not always taken when people were assessed as at risk of developing pressure ulcers. Some people did not have accompanying care plans instructing staff on how to reduce the risk. For example, one person had been assessed as being at high risk of developing a pressure ulcer in October 2015. There was no preventative care plan in place at this inspection instructing staff on how to reduce the risk. We found the person had now developed a pressure ulcer. A care plan in place instructing staff on how to support this person with the pressure ulcer wasn't sufficient. It didn't state how often the person required repositioning to promote their skin healing. Staff gave conflicting information about how often the person required repositioning, and records showed this wasn't being done consistently. This put the person at continuing risk of further skin breakdown. For several other people, assessments had identified they were at high risk of developing a pressure ulcer but there was no preventative care planning in place to reduce this risk and it was unclear how their skin integrity was being effectively managed. Staff were unable to tell us how to identify a pressure ulcer developing in its early stages, so there was a risk that these may not be picked up early enough to prevent them.

Malnutrition Universal Screening Tool (MUST) assessments for people did not feed into preventative care planning and clear action was not always taken where a risk was identified. For example, the cook told us

one person ate very little and had a low weight. However, there was no nutritional care plan in place for this person and their food intake was not being monitored. Whilst their weight had remained stable for a period of months, it remained low and it was unclear what, if any, action was being taken to boost the person's intake. Staff we spoke with couldn't tell us how they were managing the person's small appetite or what food the person particularly liked. The person was unable to communicate their needs and required the full support of staff to maintain their health and welfare.

MUST guidance was not been followed because where it guided staff to weigh people weekly this was not being actioned. The service was missing opportunities to identify risk to people at an earlier stage. We identified that the MUST scores for some people had been calculated incorrectly. For example, the scores for two people had been calculated as 'low' when they should have been calculated as 'high'. We spoke with the manager about this who said they had held extra training for staff following similar issues in the past. However, the manager had not implemented any checks to ensure risks were scored correctly and the training had been ineffective to help lower the associated risks.

People did not always receive their medicines in accordance with the instructions of the prescriber. Adequate medicine administration systems were not in place. We observed one staff member approach a person and offer them some medicines. The person refused stating, "I've already had those this morning." The staff member took the medicines away without saying anything to the person. We queried this with the staff member who confirmed that the medicines had already been administered on the morning shift but had been recorded on a different medicines administration records (MAR) sheet. During our audit of medicines we found two MAR sheets in place for each person. One was for the new cycle, and one for the previous cycle. Some staff were recording on the old MAR sheet and some on the new, This caused confusion among the staff team about what medicines had and had not been administered. There was a risk that people could be administered double doses of medicines in error if they were unable to tell staff that they had already had the medicines.

We found discrepancies which indicated people had not been administered medicines which had been signed for on their MAR. The service had not identified these mistakes because there was not an adequate system to monitor medicines administration. The manager was unable to tell us what action would be taken to ensure errors such as these would not be made in future.

This was a breach of Regulation 12: Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough staff available in sufficient numbers or with the right skills to meet people's physical, social and emotional needs. No action had been taken following our previous inspection to improve staffing to enhance the quality of life for people using the service. Many people required a high level of support from staff. However, this had not been taken into account when the staffing level was calculated. There was no formal system to monitor the effectiveness of the staffing level and the manager could not explain how they had decided that the current staffing level was appropriate. People told us that there were not enough staff to meet their needs. One person said, "Sometimes you ring the bell and you're dying to go to the toilet and you have to wait." One other person commented, "There's been a few new staff, they are short-handed". Another person told us, "They could always do with more (staff); they do get in each other's way a lot at mealtimes." Another said, "… at times they could do with more staff." We observed that people did not always receive the support they needed in a timely manner. For example, one person was calling out for support and when staff didn't respond to them, we intervened and tried to locate a staff member, but they were all busy supporting other people. This person's dignity and respect was compromised because staff were unable to provide support in a timely way.

We observed that people did not get the emotional and social support they required from staff. For example, we observed three people seated in a small dining area within the service over the course of our eight hour inspection. They received little interaction or engagement from staff. These people required a high level of support to meet their emotional, physical and social needs. For example, they required staff support to mobilise or engage in meaningful activity. The needs of these people were not being met by the staff team because staff were busy undertaking other tasks.

Although staff felt the staffing level was adequate, we observed their roles were task based and did not include any focus on importance of interaction. Staff did not have opportunities to sit with people and engage them in activity.

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

Despite these shortfalls people told us they felt safe living in the service. One person told us, "I used to get very nervous, but here there is always someone (there)." Another person said, "Here is beautiful. A lovely place."
Members of care staff were able to tell us how they would recognise abuse and what action they would take to protect people from harm. However the lack of action relating to staffing levels and risk assessment meant we were concerned that staff had not recognised this as potentially affecting the impact on the safety of those they cared for.

There were appropriate recruitment procedures in place to ensure new members of care staff had the right skills, experience and background for the role. Improvements had been made were to ensure robust recruitment systems were in place.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 12 October 2015 we identified breaches of regulations and concerns relating to consent and staff training. We found that staff did not have an understanding of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) and this put people at risk of having their rights restricted. Staff did not have adequate support and training to deliver high quality care to people. We were so concerned that we met with the provider's representatives to discuss their action plan to make improvements. This inspection was completed to check progress against the action plan. We found some progress had been made, but there were still concerns about staff practice and supervision.

Care staff told us they felt well supported by the manager and said they could raise issues or concerns with them at any time. Improvements had been made to implement a supervision system to better support staff. However, this had not yet been rolled out to all care staff. We were able to review the records of two supervisions that had been carried out. These had not been used to discuss development and training needs or as an opportunity, for example, to discuss the previous inspection report and the improvements to staff practice that were required.

Action had not been taken to improve the knowledge and skills of the staff team. The manager told us care staff had not received further training in areas which we identified were required at our previous inspection. They told us that all training, including moving and handling, was still completed in a one day session provided by an external training provider. The service had not explored whether the training provider they currently used provided training to the staff team to an adequate standard which was required to improve the quality of the care provision. Staff told us they felt the training was sufficient to provide them with knowledge of key subjects. However, this was not reflected in their practice where they demonstrated a lack of understanding of subjects such as diabetes management, nutrition, MCA, DoLS and pressure care. We remained concerned that the service could not demonstrate staff had the knowledge, skills and experience to provide people with safe care that meets the needs of those they cared for. Observations confirmed poor staff practice in some areas, such as medicines administration, obtaining consent and managing challenging behaviour.

Action had not been taken to put in place a system to monitor the competency of care staff to ensure that the training they had received was effective. This meant that the service had no way to identify where staff practice fell below the required standard and could not address this before it put people at risk of harm.

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

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 when this is in their best

interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA.

Some action had been taken to make the appropriate DoLS applications to the local authority and carry out assessments of people's capacity in line with the MCA. However, people were still put at risk of having their rights and liberties restricted because members of care staff did not have a clear understanding of their responsibilities under the MCA and DoLS. Discussions with staff showed that they did not have a clear understanding of obtaining consent, upholding and promoting people's rights and enabling people to make decisions. This knowledge had not been improved upon following our previous visit. Staff still thought it was appropriate to make decisions on behalf of people without first following an appropriate process to consider if this was in the person's best interests. We observed instances where people were not asked for their consent prior to care and treatment being provided to them. For example, staff beginning to move someone from an armchair into a wheelchair without first speaking to the person or requesting their consent. This also supported our concerns that the staff were task led rather than focussed on individuals needs and wishes.

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

Those who were more independent were able to tell us they were happy with the food and drink provided for them. Some had specialist needs. For example one person said, "I'm on a liquid diet, it's alright, I'm getting used to it (the food). I'm eating more now than when I first came here". However others did not have the same experience. One person who was diabetic had been given the wrong meal and a staff member told us, "[Person] got given the wrong food a few times by accident." It was not clear what, if any, system was in place to ensure that the kitchen staff linked with care staff so they knew about particular nutritional needs, although kitchen staff were able to tell us verbally about people they knew were vulnerable.

We saw that people were not always provided with the support they required to eat their meals. For example, the cook told us one person had not been eating much and had a low weight. We observed that the person didn't eat any of their meal, but staff removed this without first offering them assistance or encouraging them to eat something. This put the person at risk of further weight loss. We fed this back to the manager who said they would address this practice immediately.

There was confusion over whether anyone using the service required their food and fluid intake recording. Four people had nutritional care plans in place which stated their food and fluid intake should be recorded. However the manager confirmed two did not need this, and one had not had theirs monitored for the two previous weeks as staff had not completed the records. Another person's records were inconsistently completed, with gaps where no food or fluid was recorded. The manager confirmed that there was no process in place to check these records to ensure they were completed correctly and consistently. There was a potential risk that staff and the manager would not be able to identify from these records if a person was eating very little and take appropriate action to protect them from the risks associated with malnutrition.

Where we were told that advice from a dietician had been sought for people, there was no documentation to evidence what advice the dietician had given and how this was being actioned. The outcome of these referrals was not documented in people's care records.

We observed that people had access to snacks and drinks outside of meal times. However, these were still only offered at structured times which did not promote people's independence and choice should they be hungry or wish to have something to eat at another time. One person asked staff for a cup of tea, and the staff member told them, "It'll be time for tea and biscuits in about half an hour." Again this showed us that staff were task led and their practice did not support requests outside of their routine. In relation to nutrition this could mean that opportunities to encourage and support people to eat and drink more were being missed.

This was a breach of Regulation 14: Meeting Nutritional and Hydration Needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they could see the doctor or other health professionals if they needed. One person said, "A doctor comes about once a fortnight, she's very nice. A chiropodist calls every six weeks, my hair's done every two weeks and I had my nails done a few days ago." Another person told us, "I haven't been well, (manager) came and they got the doctor". Whilst we saw the manager was consulting with others about the health and welfare of people, this was not always clearly documented. For example dietician's advice was not recorded on care plans. Where staff told us people had seen the GP, this was not documented in their care records. A number of people were on antibiotics at the time of our visit, but the reasons for this were not recorded.

Requires Improvement

Is the service caring?

Our findings

At our last inspection on 12 October 2015 we found that some improvements were required to ensure that staff interacted with people in a consistently kind and caring manner and upheld their dignity. At this inspection we observed that some staff practice in this area had improved. However, some work was still required to ensure that interaction with people was not provided in a task focussed manner.

Proactive action had not been taken to ensure that the service was run in a way that promoted a culture of kindness and respectfulness among the staff team. The manager had not taken action to ensure that improvements were made which directly impacted on the ability of staff to ensure that people were treated with respect and choices consistently. For example this had not been considered in relation to staffing levels and the training staff needed to improve their practice overall. This meant that staff were still not able to provide care to people in a consistently person centred, non-task focussed manner.

People told us that staff often did not have time to sit and chat with them. We observed that some people were involved in no other activity and were not engaged or orientated with their surroundings. This meant their day was entirely focussed around daily routines. For example, meal time routines and personal care.

We observed that people were not always listened to by staff. For example, one person asked a staff member a question. The staff member responded but then ignored a second question from the person and left the room. The person asked the same question of another staff member, who did not respond. The person required support and intervention to orient them to where they were and to reassure them. Staff didn't meet this need, and the person continued to call out when staff left the room.

People told us they could be independent in the service. One person said, "They try and help me to be independent. They'll ask if I want this t shirt or that one." This was not the experience of everyone, as we observed that staff did not always consistently encourage people to complete tasks for themselves where they were able. One staff member brought a drink to one person. The person reached for the cup and the staff member said, "It'll be quicker if I just hold it for you." This did not promote or uphold the person's independence or encourage them to use abilities they still retained. It was also not clear if this approach was being taken to save time due to lack of appropriate levels of staff.

People told us they felt that staff upheld their dignity and rights to privacy. One person said, "I like to stay (in bedroom), they respect that and still come and see me from time to time." Another person told us, "Sometimes they'll stop and have a quiet word with me to see if I need help with my [personal care]." Our observations confirmed that the staff were discreet when offering people support.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 12 October 2015 we found that the service needed to make improvements to ensure that the care provided was person centred and that concerns or complaints were listened to and acted on. In addition we found that there was a lack of activities to help people spend their day in a meaningful way. We were so concerned that we met with the provider's representatives to discuss their action plan to make improvements. This inspection was completed to check progress against the action plan. We found some progress had been made, but these were incomplete. The manager shared that they did not have a revised timescale for when the work was to be completed or how they could them monitor its effectiveness.

Some work had been undertaken to implement new care planning. However, the service had been unable to update the care plans of all the people using the service within the timescale they specified. The manager told us they had been too busy to complete these and had not advised us of a revised estimate of when this could be completed

Updated care plans still did not reflect people's needs in sufficient detail to enable staff to provide consistent care. We were therefore not assured that people consistently received the care they needed.

Care records for the majority of people remained generic, and did not contain personalised information about them or their specific and individual care needs. New care plans still did not reflect people's preferences with regard to their care. For example, care plans would state the person required full support with personal care but not details such as how they liked it to be provided. Care plans did not reflect people's choices about how they wanted to be supported with their personal appearance. For example, how they preferred to wear their hair, or whether they liked to wear makeup.

People's involvement in their or their relative's care planning (where appropriate) was inconsistent. One relative told us, "They got me involved when [person] arrived here." However, another person said, "No, don't know anything about that." A staff member said, "I don't think people have much to do with them right now. They're all being updated but that's just the manager doing that." Improvements are still required to ensure people's views on their care are sought and that these are reflected in their care planning. The manager was unable to demonstrate how they intended to involve people in the development of their own plans.

Action had not been taken by the service to improve people's access to meaningful activity and engagement. People told us they were bored. One person said, "They do bingo most days but I've never been interested in that so I don't get involved. Not much else goes on." Another person told us, "I wouldn't say anything's improved in that respect, still not much to do unless you like group activities."

More independent people who were able and willing to take part in group activities lived a more fulfilled life than those who were less independent and required more staff support, for example those living with different stages of dementia. They were not supported individually to enjoy hobbies and interests or to

engage in an activity of their choice. We observed three people seated in a small dining area who required the full support of staff to engage them in activity and to interact with them to prevent them becoming socially isolated. The television in this area was on the same channel throughout our inspection and the remote control was out of reach. Staff didn't recognise this and ask if there was anything else these people would prefer to watch. We spoke to one of these people who said, "I come down here in the morning, sit in the chair all day, go to bed roughly about nine 'o' clock, that's a long day".
Care plans did not reflect people's interests. One staff member said, "You just have to get on with it. What you don't know, you don't know." Another told us, "Some people who can have a chat tell you everything about them, but then there's people who can't say nothing much and there isn't much about them in their plans." This information would allow staff to offer people personalised care and more opportunities to connect and develop meaningful relationships. Understanding and knowledge about a person can also reduce the levels of distress for people living with dementia, as staff know how to respond to their feelings and reactions in a consistent and effective way.

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

Improvements had been made to ensure that people knew about the complaints procedure, and knew how to make a complaint if they were unhappy. One person said, "If I have a grievance I tell them". Another person told us, "[I would go to manager] very much so, [manager] would definitely deal with a problem." The manager told us they had not received any complaints so we are unable to check if their responses had been effective and used to help improve the service.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 12 October 2015 we found concerns about how the service was being run because there was no quality assurance system in place. In addition the service had failed to independently identify shortfalls which meant they had taken no action to improve in certain areas. We were so concerned that we met with the provider's representatives to discuss their action plan to make improvements. This inspection was completed to check progress against the action plan.

This inspection found there remained a lack of provider oversight to ensure that improvements were being made to an appropriate standard and in a timely way. Timescales against their own action plan had either not been met or the manager advised they would not be met. No action had been taken to revise them or provide extra resources to achieve them. The manager told us that they had not had the time to complete the required improvements to the level they needed to be at. They said they had received some support from other staff members within the organisation but that this had not been able to continue as the staff were needed elsewhere. The manager had still been unable to recruit a deputy manager to support the improvement of the service, and was receiving support from the providers of the service mainly by telephone rather than in person. A member of care staff said, "Visits from the owner are very rare." Records were not available to demonstrate that the provider's representatives had been carrying out regular monitoring visits or audits of service quality.

The culture of the service at all levels demonstrated a lack of ability to recognise what constituted poor quality care and what was required to raise standards. The manager was unable to demonstrate how or if they referred to best practice guidance in key areas, for example, pressure care, dementia, and good environments for people living with dementia.

Governance systems such as quality assurance and auditing processes had not been improved upon and were not robust enough to protect people from the risk of harm. The systems in place did not independently identify shortfalls. For example, anomalies in medicines administration records had not been identified by the audit. Action had not been taken to put in place new systems which we identified were required at our previous inspection. For example, systems capable of assessing and monitoring the effectiveness of the staffing level or a system to assess the competency of staff.

There remained a lack of openness and transparency between the provider, manager and staff team about the quality of the service and what was being done to address it. Plans did not involve the staff team being empowered or supported to help with improvements. Staff told us they were aware of the report from the previous inspection visit, but that they hadn't had discussions with the management about the improvements required. One staff member said, "I found out about it from another staff member. I've not had it discussed with me by [manager]." Another staff member told us, "There's been no formal conversation or meeting about it, no. I had a brief chat with [manager] about it because I was a bit upset but that's it." As a result of this approach the culture of poor practice within the staff team remained and the quality of care people received had not improved.

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

The management of the service has not ensured that an accurate representation of the service provided at Wainford House is reflected on their website. We reviewed the provider's website and found that it stated people would be provided with "excellent care standards." This does not reflect our findings with regard to the quality of care provided.

This was a breach of Regulation 20A: Display of Ratings of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.