Care Quality Commission

Wyndham Court Limited

Wyndham Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We carried out this inspection to check that improvements had been carried out following our previous inspection on the 25th September. The findings of that visit led us to serve warning notices and compliance actions as the provider failed to meet all the requirements of the regulations. At this inspection on the 15th and 28th January 2015 we found that little improvement had occurred and new breaches of the regulations were identified.

We had asked the provider to make improvements in meeting people's health and welfare needs, infection control, records, nutrition needs, safeguarding, safety and suitability of equipment, assessing and monitoring the quality of service and completing statutory notification appropriately. At the time of our visits an action plan had not been received by CQC and we found there had been little improvement.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Wyndham Manor is a purpose built residential care home situated in a residential area of Cleator Moor, Cumbria but is within walking distance of the local amenities. Accommodation and communal space is over three

Summary of findings

floors and all rooms are for single occupancy and have en-suite facilities. There are suitable shared areas and a garden. The home provides accommodation for up to 60 older people some of whom may be living with dementia.

There was no registered manager in post at the time of our inspection. The recently appointed manager had not applied to The Care Quality Commission (CQC) for registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The people we spoke to told us they felt safe living in Wyndham Manor and relatives told us they had no worries about their family member's safety. However we found that although staff understood their responsibility to keep people safe they had not completed any accredited training in safeguarding vulnerable adults. Adult protection training had been offered to the manager by staff from the local authority but this had not been taken up by the manager.

We found that the service was not safe because people were not protected against the risks associated with the management of medicines. Administration of medicines was not recorded correctly. There were no arrangements in place to ensure that changes to medicines made in hospital were continued correctly after people were discharged back to the home.

People were still at risk because appropriate arrangements were not in place to protect people from the risks of acquiring a health care associated infection as appropriate standards of cleanliness and hygiene were not maintained.

We found that people's needs were assessed prior to their admission to the home. However records showed family members signed the care records and people who lived in the home had not been involved in the care planning process.

The home did not meet the requirements of the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). No assessments of people's capacity to make decisions had been undertaken. The MCA and DoLS require providers to submit applications to a 'supervisory' body' for authority to restrict peoples liberty. Where people lacked the ability to make a decision about living at the home no application for a DoLS assessment had been made.

All the people we spoke to expressed satisfaction with regards to the care and support they received. However some people told us they were unhappy with the menu planning as the menus were very repetitive and they would like more variety.

We found that activities were limited but a new activities co-ordinator had recently been appointed.

Staff had limited input into the care planning system and did not always read the care plans. This placed people at risk of receiving care and support that was not in line with their care and support plans. Care plans were not updated regularly and we saw that care plans did not always reflect up to date information for staff to be able to meet people's needs safely.

People had not been protected against the risk of harm because the systems used to assess the quality of the service were limited. We found that the audits completed were not effective because they failed to identify the issues we found during this inspection.

We found that records required by CQC in relation to the regulated activity were not always in place and kept up to date. For example care and support plans were not regularly reviewed and what information that was recorded in the care plans was not dated.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected against the risks associated with unsafe use and management of medicines.

There were no arrangements in place to ensure that changes to medicines made in hospital were continued correctly after people were discharged back to the home.

Safe guarding procedures were not robust. Staff had not received appropriate training in the protection of vulnerable adults.

People were still at risk of infection because appropriate arrangements were not in place to protect people from the risks of acquiring a health care associated infection as appropriate standards of cleanliness and hygiene were not maintained.

Is the service effective?

Inadequate

The service was not effective.

We found that staff training was not up to date.

People were unhappy about the quality of the menu planning.

The home did not meet the requirements of the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Requires Improvement

The service was not always caring.

All the people we spoke to expressed satisfaction with the service and felt they were well cared for.

Staff had limited input into the care planning system and did not always read the care plans.

Family members spoken with confirmed they could visit whenever they wished and staff made them welcome in the home.

Is the service responsive?

Inadequate

The service was not responsive.

We saw that care plans did not always reflect up to date information for staff to be able to meet people's needs.

Summary of findings

Care plans for the management of medical conditions did not address the needs of the people who lived at the home. This meant that staff did not always have clear guidance available to them to make sure that people received appropriate care.

There were not enough meaningful activities for people to participate in as groups to meet their social needs. This meant some people living at the home could become isolated.

Is the service well-led?

Inadequate 

The service was not well-led.

People had not been protected against the risk of harm because the systems used to assess the quality of the service were limited and not effective.

There was no registered manager in post at the time of our inspection. The newly appointed manager had not applied to CQC to register.

Action had not been taken to address the improvements required as identified at the previous inspection.

Wyndham Manor 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 unannounced inspection took place over two days the 15th and 28th of January 2015. On the 15th January the inspection team consisted of three adult social care inspectors, one pharmacy inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience had experience in the care of older people some of whom may suffer from dementia. On the 28th January 2015 the inspection team consisted of two adult social care inspectors.

Prior to the inspection visit we gathered information from a number of sources. We looked at the information received about the service from notifications sent to the Care Quality Commission by the manager. We received, from the previous registered manager a provider information return. A provider information return is a form completed by a registered manager or provider outlining details about the service and the care and support provided.

We looked at six care and support plans, spoke to 13 people who lived in Wyndham Manor, 11 members of staff and the newly appointed manager. We also spoke to seven relatives and friends who were visiting Wyndham Manor during the two days of our inspection. We also spoke to the visiting entertainer who was in the home on the first day of our visit.

We looked around the environment including the communal areas and, with permission, some bedrooms.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living in Wyndham Manor Care Home (Wyndham Manor) and the home provided them with a safe environment. Comments from people and relatives were all positive and included, "I feel safe at night - you are in your home", "I'm not worried someone could come into my room" and "The girls (care staff) will always look after you, they are family."

We spoke to members of the care staff team to see if they had an understanding of the protection of vulnerable adults. Whilst they understood their responsibility to keep people safe they confirmed they had not completed any accredited training in this subject. However from a recent poor provider meeting convened by Cumbria County Council we learnt that training in the subject of protection of vulnerable adults had been offered in this subject but the provider had not accepted the offer, resulting in staff still not having been provided with this training. We were given a copy of the training plan for the year 2014 and training in adult protection was not listed. Staff told us they would report any concerns about ill treatment to the manager but were not sure what would happen after that. The provider was unable to provide any evidence that training in adult protection was scheduled.

At our previous inspection on 25th September 2014 the provider was in breach of this regulation and a warning notice was served. The provider remains in breach of this regulation because he has failed to provide suitable training in the protection of vulnerable adults including the use of suitable restraint and how to manage behaviour that could challenge the service or the people who used the se service.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Appropriate arrangements were not in place to ensure that people were protected from abuse, or the risk of abuse.

There was unit a manager on each unit supported by 4 support workers. If staff called in sick the unit managers covered their shift which left the unit short of management. The home's manager confirmed she was recruiting new staff. They told us that they would not admit any more people to the home until there was a full complement of staff to provide the appropriate care and support. The provider also employed domestic and catering staff and a full time maintenance manager.

We looked at the personnel files for the last three members of staff appointed to work in Wyndham Manor and found they contained all the required documentation. There were completed application forms, two references, copies of contracts of employment and documents of proof of identity. All this information helped to ensure only suitable people were employed to care for

The infection control systems had improved since our previous inspection. We saw there were gloves and aprons in place together with paper towels and liquid soap in all the communal bathrooms and toilets. The home was cleaner but we did see that the waste bins in the bathrooms were not appropriate as they were open bins and not the sealed type. The manager did provide us with an infection control policy however this was out of date and did not reflect current guidance and standards expected by the department of Health (DH). There was no infection control lead in place and staff had not been provided with training.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Appropriate arrangements were not in place to protect people from the risks of acquiring a health care associated infection as appropriate standards of cleanliness and hygiene were not maintained.

As part of this inspection we looked at records, medicines management and administration and care plans relating to the use of medicines. We observed medicines being handled and we talked to staff about medicines management. We found that people did not receive their medicines in a safe way.

We looked at records and medicines in detail for four of the people that lived at Wyndham Manor. We found that there were good records of GP visits. However, appropriate arrangements were not in place in relation to the recording of medicines. Whilst the records looked well completed we saw two records that were signed for to show the medicines had been administered when they had not been given.

We found that the recording of creams was poor. We found that the senior care worker signed for the administration of

Inadequate

Is the service safe?

creams on behalf of other care workers who administered them. This could lead to incorrect records being made. Care plans and body maps for the use of creams were poor so that there was no clear guidance for staff to follow to ensure that they were used correctly. We saw one cream that was prescribed for use two or three times a day that was signed for administration once a day only. This could cause the treatment to be ineffective.

We looked at records for the handling of Controlled Drugs on one unit. The records tallied with the stock of medicines. However, we saw a record in the Controlled Drugs register that showed that a medicine was administered at 10am on the inspection date but this was not correct. The staff could not remember what time the tablet had been administered which meant the register was incorrectly completed.

We saw a senior care worker assisting one person with an inhaler and the technique was good. However, medicines were not safely administered overall. We saw a medicine that should have been given before breakfast and on an empty stomach being given immediately after breakfast. This would result in ineffective treatment. We found that where people received their medicines crushed their consent for this had not been obtained. Where people were seen as unable to give consent the proper assessments had not been done or documented to ensure that crushing medicines was in their best interests.

Arrangements were not in place in relation to checking that medicines were given correctly following peoples discharge back to the home from hospital. We saw one person who was incorrectly given a medicine after discharge that had been discontinued in hospital.

Medicines were not disposed of appropriately. We saw a tablet being flushed down the sink which was inappropriate.

We looked at care plans relating to medicines and associated medical conditions.

We found that these were poor. There was no care plan in place for the management of seizures for a person who was on a medicine to control them. There was no care plan in place for a person who was prescribed a 'when required' painkiller. Staff told us that this person did not have capacity to verbally express their need for pain-killers. This meant that staff did not have clear guidance available to them to make sure that people received appropriate care.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Appropriate arrangements were not in place to demonstrate that people received all their medicines appropriately.

Inadequate

Is the service effective?

Our findings

People we spoke to made many positive comments about the support they received from the staff in the home. One person told us, "It is great living here much better than living alone". We spoke to a relative who was visiting and they were very pleased with the care and said, "My relative was one of the first people to move into the home and I have never regretted them moving in. The staff provide really good support and keep me informed about any changes or things I need to know".

We found that the training to staff was very limited. We were given a copy of training plan outlining staff training for 2014. We saw that some training was planned for June and November but could find no evidence this had taken place. There was training scheduled for January 2015 but up to the time of our visits this had not been completed.

The manager informed us that staff supervision had not taken place at regular intervals and the records we saw indicated that the last supervision staff received was in April and June 2014. Only one member of staff spoken to was able to confirm that she had received supervision in recent months. Lack of supervision could mean that staff were not supported to provide effective care and support.

There has been very few staff recently employed as there remains a long standing staff group that had been in post since the home opened. We looked at the induction records for new staff. We were told by the manager that they used the Skills for Care, Common induction standards. We found that the records of the induction process were incomplete and failed to record accurately the induction training provided and the level of competence achieved.

This is a breach of Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting workers because the registered provider had not made arrangements to ensure staff were properly trained, supervised and appraised.

The service did not have in place a copy of the Code of Practice in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA and DoLS provide legal safeguards for people who may be unable to make decisions about their care.

On the day of our visit no member of staff or the manager had undertaken training in MCA and DoLs. They were unable to demonstrate a good knowledge of the requirements of this Act. There was no evidence of best interest meetings or mental capacity assessments. People who used the service had not been asked for their consent in relation to care planning and consent to treatment. We saw fourteen records and twelve of those records stated that people had received a seasonal flu injection without their consent, and that consent had been sought from a relative. The manager had not recorded the decision making process. There were no records to show that the person receiving the injection had been able to give consent. Where relatives had consented on their behalf, there were no records to demonstrate that they had the legal right to make such decisions.

We noted a number of occasions where people were not asked for their consent to care and treatment. For example one person had a bed rail in place and one person was in a chair that was tilted back to restrict their movements. There was no documentation to support these restrictive practices with no best interest meeting being held. These practices were considered to be a method of control. The correct procedures had not been followed to demonstrate how these decisions had been made and if these were the least restrictive methods of keeping people safe.

There had been no best interest meetings arranged to discuss deprivation of liberty safeguards for people who lived in Wyndham Manor. The manager confirmed that no DoLS or mental capacity assessments had been completed. We discussed this with the manager because we saw the use of a tilting chair and bed rails which were restricting peoples movement around the home.

We saw care plans in respect of people who lived in the unit that supported people who lived with dementia and other complex needs. We noted that they had been reviewed and updates in December 2014. However, when we looked at these in more detail we found no evidence that people had given their consent for treatment or support. The care records had all either been signed by a relative or left blank.

There was no information in people's records about advanced decision making for people or if anyone had lasting power of attorney for people living in Wyndham Manor. The manager was not aware if any family member

Is the service effective?

had lasting Power of Attorney in respect of finance and care and welfare. This meant that information about people's legal rights and human rights was not available for staff to be able to give people the appropriate support.

When we spoke to senior care staff they did not understand the law in relation to lasting Power of Attorney (POA) and thought that if a relative had POA that gave them the right to control everything including care decisions.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of people who lived in the home.

There were a number of people using the service who had difficulty in maintaining a healthy diet. There was evidence that the Speech and Language therapist (SALT) had been requested. However care plans had not always been updated in line with the advice given. One person was at risk of choking, the SALT had advised stage 2 thickened fluids but their care plan stated that they should receive stage 1 thickened fluids. This put this person at risk. Another care plan stated that the person had no special dietary requirement but again the SALT had advised thickened fluids due to the risk of aspiration. Another person had lost weight since admission and had fortified food supplements. However, their care plan also stated 'no special dietary requirements'. The daily notes recorded that this person had frequently refused food. There was no evidence of any action being taken to ensure this person was receiving a balanced and nutritious diet.

Nutritional assessments using the Malnutrition Universal Screening Tool (MUST) were in place but not all of them had been signed and dated. We saw evidence that the SALT had been requested to assess some of the people that used this service. Care plans indicated where the use of thickeners had been prescribed and soft diets recommended. None of the intervention details were signed or dated, making it impossible to tell whether people received the correct support and treatment

Food and fluid charts were in place for people deemed at risk of malnutrition and dehydration. These records lacked detail and only recorded what food had been offered and not what had actually consumed. These records were kept in the care office and not in the person's room which increased the risk of staff forgetting to complete them accurately at the time food and drink was offered.

Food and menus were an issue throughout the home. People told us the menus were very repetitive and they knew what meal was coming and when without looking at the menu. They said, "The food is adequate but the menus could be more interesting". Most of the people we spoke to told us of their dissatisfaction with the food and meals at the home. The weighing scales were broken on the first visit so weights were not regularly recorded although by the time of our second visit new ones had been purchased

This is a breach of Regulation 14 of the Health and Social Care act 2008 (Regulated Activities because people were not supported to have adequate nutrition and hydration.

Health care needs were met by people's GP and the district nursing service. People and relatives told us doctors' visits were organised by the manager and there was never a problem getting the doctor to visit. Whilst we were in the home an NHS district nursing team member came into the home. They obviously had a very good relationship with the care staff and they worked together to monitor the progress of the person she was visiting.

We asked the manager on the unit that provided support to people who lived with dementia if there were people whose behaviour could challenge the service or the other people who lived there. At our first visit the unit manager told us that there was no one who presented such a challenge. However they told us during the later visit that there were some people that could display aggression and challenge the staff and other people. We saw from the information we held about the service, that there were times when people had shown aggression or behaviour that could challenge.

We saw from the training records that no staff had completed accredited training in this subject. According to the training plan it was scheduled for November 2014 but had not taken place. When we asked staff how they dealt with such situations they said, "We make sure the person is safe and with another member of staff then we walk away then come back later". The lack of training place people at risk of receiving inappropriate care.

Requires Improvement

Is the service caring?

Our findings

We asked people and their relatives if they were happy with the care and support provided by the staff at Wyndham Manor. All the replies we received were positive and people asked us to make sure we put their comments in our notes. They said, "They (the staff) are not just doing a job they really care", "The girls are lovely and make it feel like home" and "You can have a laugh with the girls". Relatives told us, "These girls do a fantastic job and don't let anyone say different" and "I have never heard a sharp or less than supportive comment when staff were talking together or to a resident".

From our observations there was an excellent, warm relationship between the staff and residents. Staff knew the people they supported well and we saw they responded well to their support needs. We asked if the staff were involved in the care planning but they confirmed it was the unit managers that reviewed and updated the care plans. Staff told us they did not always read the care plans but depended on the staff handover to be kept up to date with the peoples' needs.

Some people in the home found communication difficult because of the symptoms of their mental ill-health or other complex needs. We observed the way staff dealt with people living with different medical conditions. We saw staff who dealt patiently and sensitively with the people they supported. We saw people living with dementia responded well to the staff group.

People and visitors told us they thought the care provided was very good and they had no concerns at all. However, people were placed at risk because the staff lacked the underpinning knowledge gained through training and a thorough knowledge of the care planning system.

Visitors were welcome at any time and we spoke to eight relatives over the two days we were in the home. All the comments were very complementary and they told us there was no restriction on visiting times. We asked family members if they were kept informed about their relative's care. They told us, "The staff are very good about letting us know if there is anything wrong or there are changes. I have known the new manager for a long time and I know she would call me if there was anything I needed to know".

We saw on the notice board there was a leaflet about the use of an advocacy service if anyone needed advice or assistance. The manager confirmed there was no person in the home who needed this service at the time of our inspection visit. An advocate is an independent person who can support people to make or express their decisions which ensured that the person's views and opinions are heard.

Inadequate

Is the service responsive?

Our findings

We asked people who lived in Wyndham Manor if the management and staff were responsive to their needs. We received mostly complementary comments but some less so. One person told us, "I only have to ask and whatever I want is there" and "The staff know what I like and what I prefer to do like having my meals in my room". Another person told us they didn't always see their doctor when they wanted if the staff didn't think it was necessary.

We spoke to one person who said they did not feel consulted about their care and had not been asked to give permission before a procedure was carried out. They said that they had never seen their care plan or knew if they should have one. We asked them about the quality of care they received. They seemed pleased with it and added, "My main complaint focused on the lack of consultation."

Care plans were reviewed by the unit managers. We were told that they were allocated protected time in order that care plans were appropriately and regularly reviewed. The unit managers said that if they were short staffed they lost this protected time as they were required to work on direct care duties. This meant that the reviews were sometimes carried out in their own time.

Care plans were inconsistent, some had been reviewed and others had not. Some care plans clearly indicated that they should have been reviewed at least weekly due the changing care needs of the individual. One care plan said that a person was at risk of developing pressure sores and that the care plan should be reviewed weekly.

This had not occurred and the last recorded date of it being reviewed was on the 10th December 2014 which was six weeks previous to our visit. Staff did not have clear guidance available to them, for example, managing medicines and associated medical conditions and conflicting nutritional assessments.

One person's records that we looked at showed that their care plan had been reviewed whilst they were away from the home and in hospital. A reassessment and update to the care plan had not taken place on their return to the home. This placed people at risk of inappropriate and unsafe care due to their changing needs following their discharge from hospital.

Not all care plans were signed by the person receiving the care. In most cases care plans had been signed by a relative or not signed at all.

This is a breach of Regulation 9 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2010 because the registered provider did not take proper steps to ensure people received care that was appropriate and safe.

There was a complaints procedure in place but it was not up to date. The provider told us that there was a copy of the procedure on display in the foyer of the building. However, the staff we spoke to were unaware that this document was on display at the home. The procedure for making a complaint was included in the home's Statement of Purpose and staff told us of this. However, the complaints procedure was not explicit of the action the manager would take to resolve any complaints raised. We did ask people and visiting relatives if they were aware of the procedure to follow if they wished to make a complaint. They all said, "I would speak to the manager if I had to complain".

We saw there was an activity programme and we were informed that an activity coordinator had recently been employed. However this person was not on duty at the time of the inspection. We did observe a group musical activity on the first day of our inspection. This was well attended by people from all the units who enjoyed joining in the songs. The home had a hairdressing salon on the ground floor and we saw this was busy and made good use of whilst we were in the home.

During our inspection we saw little use was made of the ground and first floor lounges because all the people remained in their rooms. Whilst we were in the home we saw no attempts being made to encourage these people to socialise. This could result in people becoming isolated in their own rooms.

Inadequate

Is the service well-led?

Our findings

The registered manager had recently left the home and the long standing deputy had been appointed as manager. Since our inspection visits we have been notified, by letter, of the change of manager. The provider had also submitted a formal notification as required by Regulation 6 of the Health and Social Care act 2008 (Regulated Activities) regulations 2010, but this was not received in a timely way as a number of weeks had passed following the registered manager leaving the employment of Wyndham Manor.

The CQC has not yet received an application for the new manager to formally register with the commission and this is also a requirement under the Health and Social Care Act 2008. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The new manager will require support, supervision and guidance from the registered provider. The new manager told us that she had not been given a job description for her new role. The provider should ensure she has full information about her role and responsibilities, not only as the manager of the home but also with regard the Health and Social Care Act 2008 if/when she is registered. It is of concern that the new manager had been the deputy manager since the home opened and had not addressed the issues raised in the previous reports to promote the improvements required. The new manager is accountable to the registered provider and a support mechanism needs to be in place to ensure the necessary improvements are made.

The provider did not have robust systems in place to quality assure the records were required to be maintained. There was no formal system to audit the care records which meant people could be at risk of receiving care that was not appropriate, safe or suitable to meet their assessed need.

The provider did not have robust systems in place to quality assure the records were required to be maintained. There was no formal system to audit the care records which meant people could be at risk of receiving care that was not appropriate, safe or suitable to meet their assessed need.

This is a breach of Regulation 20 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2010 because the registered provider did not take proper steps to ensure records about care, treatment and support of people who used this service were not up to date or accurate.

The provider did not have a formal process for carrying out internal quality audits or checks to assess and monitor the care and support provided. Care plans, medicines, health and safety, infection control, falls, accidents and records were not routinely audited. However the manager has recently started to look at the environmental standards throughout the home each month. The audits that were in place had been undertaken by a member of the provider's family and the records completed were very minimal. There was no evidence that the quality of the service was being effectively monitored by the provider or that the improvements necessary were understood and being addressed in a timely manner.

We did not see a formal structure of meetings where residents, relatives and staff could discuss any problems or comments that they had with regard to the running of the home. We were told by people we spoke to that there had been some informal meetings but owing to people feeling that they accomplished little they were not well attended. From talking to people who lived in Wyndham Manor and staff working there, we found that there was a lack of communication about how the home was run. People who lived in the home told us that they had little input into this area.

This is a breach of Regulation 10 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2010 because the registered provider did not have an effective system designed to regularly assess and monitor the quality of services provided.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person did not take proper steps to ensure each service user received care that was appropriate and safe.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person did not have effective systems in place to monitor the quality of the service delivery.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The registered person did not have effective systems in place to protect people from the risks of acquiring a health care associated infection as appropriate standards of cleanliness and hygiene were not maintained.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person had not made suitable arrangements to ensure people were safeguarded against the risk of abuse.**

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe administration and recording of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person did not have suitable arrangements in place for ensuring people were protected against the risks of inadequate nutrition and hydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place to ensure that people employed for the purposes of carrying on the regulated activity received adequate training.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of people who lived in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

This section is primarily information for the provider

Enforcement actions

The registered provider did not take proper steps to ensure records about care, treatment and support of people who used this service were not up to date or accurate.