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

Summary of findings

Overall summary

This inspection was carried out on 5 October 2017 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 16 people living at the service at the time of our inspection.

At our inspections in May 2015, July 2016 and March 2017 we found the service was in continued breach of several regulations. We required the provider to make improvements and when they did not we placed the service into special measures and took enforcement action against the provider. This process has concluded and we cancelled the provider's registration to provide accommodation and personal care to people at Fourwinds Residential Care Home.

A manager was working at the service. A registered manager had not been leading the service since May 2015. The manager had applied to be registered but withdrew their application following our inspection. 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 and had not taken sufficient action since our last inspection to support staff to provide a consistently good service. The manager began working at the service in June 2017 and told us they had not been supported by the provider to fulfil the role and make the necessary improvements to the service. The provider however told us they had supported the manager, including employing consultants to support improvements.

The manager and staff did not understand the visions and values for the quality of the service provided. Checks on the quality of service provided continued to be ineffective and the shortfalls in the service we found at this inspection had not been identified. The views of people, their relatives and stakeholders had not been used to improve the service. Staff had not been asked for their views about the service or been involved in planning the necessary improvements.

At our previous inspections we required the provider to make improvements to staffing levels. Staffing levels had increased, however; staff were not consistently deployed at the right times to meet people's needs. People who needed support to tell staff about their needs and wishes, because they could not communicate using speech, received little support and attention from staff. People told us they had to wait for the support they needed at times.

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

Staff knew the signs of possible abuse but were not confident to raise concerns they had with the manager. They were still not confident to raise any concerns with the provider as they felt they would not take any action.

Previously we required the provider to make improvements to the way risks to people were managed. Action had not been taken to manage all risks and people continued to be at risk of choking or developing skin damage. An analysis of accidents had not been used to identify any changes in people's needs and then plan care to reduce risks to them. Improvements to the way medicines were managed had not been sustained and people were at risk from poor medicines management.

Food was not always prepared to meet people's needs, including people at risk of choking. Menus did not offer people a balanced diet. People were not involved in planning the meals provided at the service. People were not supported to stay as well as possible.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS authorisations had been granted for five people who lacked capacity to consent and were restricted. Imposed restrictions on people had not been reviewed to ensure they were kept to a minimum. We observed one person asking to go out being stopped from doing so by staff and staff were not working within the framework of the person's DoLS to support them to go out.

Staff did not follow the principles of the Mental Capacity Act 2005 and people were not supported to make decisions. Assessments of people's ability to make day to day decisions had not been completed and guidance had not been provided to staff about how to support people to make decisions.

People and their relatives continued not to be involved in planning their care. People's care plans had not been regularly reviewed to identify any changes in their needs. Care plans had not been up dated when people's needs changed and up to date guidance was not available to staff about people's needs.

Although people and their relatives told us that staff were caring, people were not always treated with respect. Staff continued not to listen and respond to people's requests, including requests for drinks. Activities some people took part in had improved however other people continued not to be supported to take part in any social activities. People told us they had privacy.

A new complaints process had been introduced. However, some people told us they were not confident to raise concerns they had with the manager and the provider.

Records about the care people received continued to be inaccurate and incomplete. Dates had not been fully recorded so staff and health care professionals could refer to the most up to date information. People's personal information was now stored safely.

The provider had not notified us of four notifiable events so we could check that appropriate action had been taken. The CQC performance rating was now displayed at the service, as required.

When staff were employed by the service, all the required recruitment checks had been completed,

including obtaining a full employment history. 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.

Improvements had been made to the environment, some areas had been redecorated and some new furniture purchased.

The overall rating for this service has been 'Inadequate' for more than 12 months and service was in 'Special measures'. We kept the service under review and took action in line with our enforcement procedures. We cancelled the provider's registration for the service and the service has closed.

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.

Action had not been taken to manage and reduce risks to some people.

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

Staff with the right skills and knowledge to meet people's needs did not work at the service every day and night.

Staff knew how to recognise the signs of abuse.

Checks were completed on staff to make sure they were honest, trustworthy and reliable before they worked alone with people.

Is the service effective?

Inadequate

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 not completed all the training they needed to meet people's needs.

Food was not always prepared to meet people's needs.

Staff did not follow the principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

People's health needs were not always met.

Is the service caring?

Requires Improvement

The service was not caring.

People were not always treated with respect.

People were not involved in planning the service they received.

Staff did not have detailed information about people's life to

help them know how they preferred their care to be provided.

People said that staff were caring and gave them privacy.

Personal information was held securely.

Is the service responsive?

Inadequate

The service was not responsive.

Care had not been planned when people's needs changed.

Some people were not supported to take part in activities they enjoyed.

People and staff were not confident to raise concerns with the manager and provider.

Is the service well-led?

Inadequate

The service was not well-led.

There had been no registered manager for over two years.

Checks completed on the quality of the service were not effective.

The views of people, their relatives, staff and other stakeholders about their experiences of the service had not been used to improve the quality of the service.

Records about the care people received were not consistently accurate.

The provider had not notified us of notifiable events so we could check that appropriate action had been taken.

The performance rating was now displayed at the service, as required.

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 5 October 2017 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, the provider completed a Provider Information Return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at action plans and notifications received by the Care Quality Commission which a provider is required to send us by law. Notifications are information we receive from the service when significant events happen, like a death or a serious injury. We reviewed information we had received from other sources including health and social care professionals.

During our inspection we spoke with 12 people living at the service, one person's relative, the manager, the provider and five staff. We visited some people's bedrooms, with their permission; we looked at care records and associated risk assessments for six 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 looked at medicines records and observed people receiving their medicines.

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

We last inspected Fourwinds Residential Care Home in March 2017 and rated the service Inadequate overall.

We found that the provider was in breach of a number of regulations and we took enforcement action.

Inadequate

Is the service safe?

Our findings

People told us they felt safe at the service. One person told us, "I feel contented and safe". However, we found that people were not always receiving safe care at Fourwinds Residential Care Home.

At our previous inspections we found that the provider had not deployed sufficient staff to keep people safe and meet their needs. This was a continued breach of regulation and we took enforcement to cancel the provider's registration.

At this inspection we found staff with the right mix of skills were not deployed to keep people safe and respond to unforeseen events. For example, during the week of our inspection a staff member with emergency first aid skills was not scheduled to work at the service at weekend or at night to respond to emergencies. The managers review of accidents showed people had fallen at night.

The provider told us when people who were at risk of choking chose not to eat in the dining room, they did not have enough staff deployed to check people were safe because staff were busy supporting people in the dining room. We observed people at high risk of choking eating alone in their bedroom or lounge and were not checked by staff. One person at high risk of choking ate alone in a lounge with no means to summon staff support such as a call bell. Staff had not been deployed to check on their safety and there was a risk that staff would not identify and respond if people choked.

The manager had deployed one additional member of care staff during the day but had not made sure staff had the skills and experience to meet people's needs. On the day of our inspection this staff member was an agency member of staff. The shift had not been planned and staff had not been allocated roles and responsibilities. The agency staff member had not worked at the service before, was not supported by an experienced member of staff and had not attended the handover to understand people's needs. We observed this staff member did not interact with people or support them with basic needs such as having a drink.

Meals were often prepared by a member of care staff as two cooks had left and not been replaced. The staff member cooking the meals during our inspection was not trained how to prepare foods to meet people's needs, such as soft diets. We observed one person who required soft foods eating hard and crunchy foods which increased their risk of choking. We asked the provider how they made sure staff deployed to prepare meals were competent. They told us their criteria for selecting staff was to choose "someone who has cooked for us before". Staffs' skills and competency to prepare meals to meet people's needs had not been considered when making the decision to deploy them.

People's comments about staffing levels included, "There are usually enough staff, and fortunately I do not often need help as there are plenty here who do", "If I call in the night they come within a minute or two but can take longer if they are with someone else at the time as there are only two staff on at night" and "I feel the girls all know what they are doing but sometimes they can be a bit rushed". People told us they felt lonely at times and staff did not have time to spend with them. During the inspection we observed staff did

not have time to sit and talk with people and spent their time providing people's person care.

At our last inspection we found that the previous manager had not correctly completed a tool they used to decide how many staff were required to meet people's needs. Since the inspection the new manager had contacted the local authority commissioning team requesting a 'dependency tool'. They had not received this. They had not taken action to look at other ways of assessing how many staff, with the right skills and experience, were required to meet people's needs at all times, such as observing staff shifts to see when staff were rushed.

The provider had failed to deploy sufficient numbers of skilled and experienced 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.

At our previous inspections we found that the provider had failed to consistently assess the risks to people and take action to manage risks. This was a continued breach of regulation and we took enforcement action to cancel the provider's registration. Action had been taken since our last inspection to assess and manage some risks but the provider had failed to mitigate risks relating to people choking and losing weight.

One person told us, "I'm at risk of choking. If I start to choke I usually manage to cough it up myself". A speech and language therapist had advised staff about how to reduce risks to the person, including constant monitoring whilst eating. This guidance was not followed and we observed the person eating meals alone out of sight of staff. Steps had not been taken to mitigate the risk such as a bell to summon staff support in an emergency or regular checks by staff. We raised a safeguarding alert to the local authority safeguarding team following the inspection.

Risks of people losing weight had not been reviewed regularly and action had not been taken when people had lost weight. One person had lost 1.7 kg (3.5 lbs) in August 2017; they had not been weighed since this time. Their malnutrition risk assessment had not been reviewed and staff had not taken action to prevent the person from losing more weight, such as referring them to health professionals. Another person's risk assessment written in August 2017 required measurements were taken of their arms, fortnightly to assess their body mass index. The risk assessment was reviewed on 22 August and stated '[measurement] weekly still in place'. The measurements had not been taken since August 2017 and further reviews had not been completed. There was a risk changes in the person's weight would not be identified.

Assessments of the risk to peoples' skin health, such as the development of pressure ulcers, had improved but had not been completed consistently. For example, one person was assessed as being at high risk in June, July and August 2017 but had not been assessed in September to check if their needs had changed. Another person preferred to remain in bed for their comfort and required support from staff to change their position frequently. Guidance about how to support the person was available but had not been followed by night staff. The person was not assisted to change their position regularly at night as recommended by their nurse and this increased their risk of developing pressure ulcers.

Accidents were recorded but had not been reviewed to identify trends or patterns for individuals to reduce risks to them. One person had repeatedly fallen and action had not been taken to support the person to remain as safe and independent as possible. Referrals to the relevant health professionals had not been made in a timely way and left the person at risk of falling again.

The provider had failed to consistently reduce the risks to people's health and safety and take action to manage risks. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Previously we found pressure relieving equipment like special mattresses and cushions was not always used correctly. At this inspection we found that equipment was being used correctly and staff knew the correct settings. Guidance was available for staff to refer to. Additional equipment to support people to move safely, including hoist slings had been purchased and staff had completed practical moving and handling training. We observed people being moved safely.

At previous inspections we found people were not always protected from the risks of unsafe medicines management. Some people were prescribed creams which needed to be applied to their skin to keep it healthy. A relative told us that their loved one's creams had not been applied as prescribed and their skin had become very dry. They had raised their concerns with the local authority safeguarding team at the time of our inspection. Records showed that staff continued not to support people to apply their prescribed creams regularly and there was a risk that people's skin would become sore and broken. The provider had identified this but action had not been taken to make sure people's creams were applied correctly.

Previously the management of high risk medicines had improved however; the improvement had not been sustained. Medicine administration records (MARs) for high risk medicines contained gaps and the reason people had not taken their medicines, such as declining was not always recorded. The manager and staff did not know why one person had declined or had not been offered their important pain relief medicines on occasions. Accurate information about why people had not taken medicines was not available to health care professionals, such as people's doctors to assist them to identify changes in people's needs. Entries in medicines records had not been completed as required by the provider's medicine management policies for example appropriate code on the MAR had not been used when medicines had been declined.

Medicines had not been ordered to make sure they were always available to people when they needed them. Before our inspection an allegation of abuse was confirmed by the local authority safeguarding team in relation to one person not having their medicine for over a year. The manager told us another person's 'when required' pain relief medicine had been out of stock for 'quite some while'. When they identified this they ordered the medicine however they did not make sure that the medicine was received promptly. The person continued to be without their medicine for almost three weeks. The person had been asked if they required pain relief during this time and records show they had not required it. However, action had not been taken to make sure pain relief was available should the person need it.

Medicines which had been refused and needed to be disposed of were not locked away. Records of medicines awaiting disposal, including those which people no longer required or were out of date had not been maintained and the manager did not know that there was a large stock of medicines waiting to be returned to the pharmacy in the medicines room with medicines that were being administered. There was a risk that these medicines could be administered to people. The provider did not have a policy in place for the storage of medicines awaiting disposal in line with national recognised guidance such as National Institute for Clinical Excellence guidance.

One person had chosen to administer their own medicine. A risk assessment had been completed in October 2015 and stated that staff would monitor the person's medicines each day and review the risk assessment every six months. The risk assessment had not been reviewed since October 2016 and staff were not supporting the person to check they were taking their medicines as prescribed. Large print MAR had been written to support the person to record their own medicines. The manager told us they planned to begin using these on the day of our inspection. There was a risk mistakes would not be identified.

Some people were prescribed medicines 'when required', such as pain relief or inhalers to help them breath more easily. Guidance had not been provided to staff about some 'when required' medicines people needed to stay well. One person required an inhaler at times to help them breathe. Guidelines were not in place to help staff recognise when the person required their inhaler and the person was unable to tell them. There continued to be a risk that people would not receive their medicines when they needed them or would be given their medicines when they were not required.

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 continued of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were now stored at the correct temperature. We observed people receiving their medicines and this was done in a kind way. One person told us, "I have my medicines all brought to me when I need them so I don't forget".

Our three previous inspections found there were not enough call bells in the lounge and visiting professionals had asked the provider to make sure people were able to call for assistance when they needed it. People still did not have access to call bells, however during this inspection we observed that there was a member of staff in the lounge to respond to people's needs and make sure they were safe. This was an improvement on our previous inspections

A number of rooms were being refurbished during this inspection. Unused rooms were now kept locked and tools and decorating equipment were no longer accessible to people. Risks associated with the balconies and garden gates had been mitigated since our last inspection. The key to the garden gate was kept safely close to the gate and the door to the first floor balcony was kept locked. The cleanliness of the building and equipment had improved. New armchairs and other furnishings had been purchased and areas of the service had been repainted.

Our last two inspections identified risks associated with emergency evacuation. Since then staff had practiced using evacuation equipment to assist people to move from the first floor and told us they were now confident to use it. Some people who required assistance to evacuate now had bedrooms on the ground floor where it was easier for staff to assist them. Fire safety systems were in place and checked regularly.

Previously we found that people had not been protected from the risk of being scalded by hot water. Regular checks of the water temperatures were now being completed. Areas of the service, including equipment used by people, people's bedrooms and the shower room were clean.

Staff knew how to recognise signs of possible abuse and how to report it. They knew about the different types of abuse. Some staff had completed training on keeping people safe since our last inspection. However, other staff including care staff had not completed the training. Staff told us they were not confident to raise concerns they had with the manager and continued not to have confidence in the provider to deal with concerns properly so would raise concerns with other agencies. The manager had raised concerns they had identified with the local authority safeguarding team.

At our last inspection we found that people were not supported to manage their money when they wanted to and this had caused one person distress. Action had been taken since our last inspection and people now had access to their money when they wanted it.

People were supported by staff who had been recruited safely. The manager completed Disclosure and Barring Service (DBS) criminal record checks before people started to work at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services. Written references were obtained and included the most recent employer. Records of the interviews were kept and notes were made of any gaps in employment. These checks were completed to make sure new staff were honest, reliable and safe to work with people. The manager had met with staff when performance issues had been identified and followed the provider's disciplinary procedures when needed.

Inadequate

Is the service effective?

Our findings

At our previous inspections we found that the provider had failed to make sure that staff received appropriate training, support and development. This was a continued breach of regulation and we took enforcement action to cancel the provider's registration. At this inspection we found there had been some improvements to the training staff had completed, however staff and the manager continued not to be supported to develop their skills and fulfil their role effectively. One person said, "I would say all the old staff are well trained and knowledgeable and I trust them all".

The provider told us that staff completed an induction when they began working at the service but records did not confirm this. The induction training did not follow, and was not modelled on current guidance in line with the Care Certificate standards. The Care Certificate is an identified set of standards that social care workers adhere to in their daily working life. No checks were completed after the induction to check on staff knowledge and competency. We looked at staff files for the three newest staff to check their induction. Only one contained records relating to an induction. We observed two new staff members move a person using a hoist, they had not been trained by the provider and their competency to move people had not been assessed. The person was moved safely however they were anxious and appeared to be in pain and the staff did not offer reassurance or inform them of what was going to happen.

Following our March 2017 inspection all staff had been or were in the process of being trained to administer medicines and this was happening during our inspection. The provider's action plan dated 3 October 2017, stated that the training had been completed but competency assessments of staff were needed. No date had yet been set for the completion of the competency assessments but newly trained staff were administering medicines. They told us they did not feel confident to do this safely and had raised their concerns with the manager but had not received support to validate their skills.

Staff had completed training on topics, such as moving people safely, fire awareness and health and safety. However, there were still gaps in staff's skills and competence in relation to individualised care, equality and diversity, and first aid. We observed that people were not treated equally and people living with dementia did not receive the same support to participate in their care as other people. For example, one person spent their time walking around the building and chatting to them self. Staff did not interact with the person or try to engage them in activities. Training had not been planned to make sure staff developed all the skills they needed to fulfil their role and kept up to date with best practice.

Staff told us they did not feel supported by the manager or the provider. They had not met with a senior member of staff to discuss their performance and development since 2016. The manager confirmed that they had not completed any planned supervision with staff because they had not received the support they needed from the provider to do so. A schedule for staff supervision was planned to take place in October and November 2017.

The manager had not received one to one supervision since they began working at the service and did not feel supported by the provider. The provider had told us they did not have the skills to support the manager

in all areas of their role. They had made arrangements for some support to be provided by a consultant and the manager of another service, however this was limited to support with policies and procedures and not the day to day running of the service. The provider confirmed they had not made arrangements for the manager to have 1:1 supervision where they could discuss their challenges and personal development. The manager was unclear about their role and responsibilities, for example how to take action to address staff performance. The provider and manager had not discussed the support and resources the manager needed to make the required improvements despite the manager requesting this. Areas of the provider's improvement plan not being addressed.

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 continued breach of Regulation 18 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked to see if the provider had made improvements since our last inspection to work within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were complied with.

Staff, including the manager and deputy manager had not completed training in relation to the Mental Capacity Act and Deprivations of Liberty Safeguards. Some people were living with dementia and there was a risk they would not receive the support they needed to make decisions. The provider's action plan stated that staff knowledge and competence would be checked by 1 October 2017. They had identified in their October action plan that this had not taken place but a revised deadline had not been set.

People's capacity to make other decisions, such as to have the annual 'flu jab' had not been assessed. Some people received their 'flu jab' during our inspection and others declined. When people were not able to make the decision to have their flu vaccination, the manager had not arranged for decisions to be made in people's best interests by people who knew them well, such as staff, their relatives and health care professionals. The relative of one person, who may have lacked capacity, had asked to be involved in the decision about whether they had a flu jab or not. They had not been invited to be part of the best interest decision and the person had not been offered the choice to have the vaccination in a way they understood. The provider's action plan dated 3 October 2017, identified that further development of MCA assessments and best interests decisions was required but no date had been set for the completion of this action.

People's capacity to make day to day decisions had not been assessed since our last inspection and guidance was still not available to staff about how to support people to make decisions. Experienced staff described to us how they supported people to make day to day decisions such as showing them objects and offering a limited number of choices. However, there was a risk that new staff and agency staff who did not know people well would not support people to make decisions in ways that suited them best. We observed an agency staff member not offering people a choice of drinks at mealtimes.

Some people were being prevented from leaving or were under constant supervision so a DoLS authorisation was needed to ensure this was lawful. Some people had DoLS authorisations in place; however imposed restrictions had not been reviewed to make sure they were the least restrictive. We observed one person who had a DoLS in place tell staff several times they wanted to "Go out for a breath of fresh air". Each time staff stopped the person from going out into the garden and returned them to the lounge. This upset the person and they became agitated. We asked the manager why the person was not allowed to go out and they said that they were able to go out. This information had not been shared with staff and the person was being prevented from going out. The provider's action plan, identified that some people had new DoLS authorisations in place and that actions were required including 'Care plan to be updated to reflect conditions'. This action had not been completed. People moved freely around the building without restrictions.

The provider had failed to act in accordance with the Mental Capacity Act 2005. The provider had restricted people's liberty of movement. This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meals continued not to meet people's needs and preferences, including soft foods to reduce the risk of people choking, despite this information being available to staff in the kitchen and in guidance from health care professionals. The staff member preparing meals on the day of the inspection had not been trained to prepare foods in the way each person needed. For example, a Speech and Language Therapist had recommended in September 2017 one person did not eat bread. We observed the person eating toast, their care plan written in August 2017 said they enjoyed toast in the morning and sandwiches and had not been reviewed and updated to include the guidance from the therapist. The person had not been offered an alternative. This increased their risk of choking.

Since our last inspection staff had stopped following the menu and meals were not planned to make sure they were balanced, or ensure people were offered a variety of foods. We asked staff and the manager why the menus were not being followed. They did not know. People did not know what was on offer each day. Meals prepared were not always recorded. Staff preparing meals told us they did not know what people had eaten in the days before so they could offer them different meals and a balanced diet.

People were not involved in planning the menu, one person said "I asked for scampi on the menu but we have only had it once in a year so I wouldn't say we get much of a say for what's on the menu". We observed one staff member at tea time tell another, "Can you go and give them all a cake please". The staff member placed a cake on each person's plate. People were not given a choice and low sugar cakes were not offered to people living with diabetes.

Care was not consistently planned to keep people healthy. We looked at two people's diabetic care plans. One described the person's normal blood sugar levels, the other did not so staff did not know when it was too high or too low. Detailed guidance was not provided to staff about how to recognise when people's blood sugar levels were too high or too low and the action to take to keep them safe.

Records showed that one person's blood sugar levels had been significantly higher than their usual range on 15 occasions in September and October 2017. Guidance to staff required them to inform the community nurse of any high readings and follow their advice. Staff had received advice but not recorded it and staff were not able to tell us what action had been taken. Both care plans said to offer the people food if they blood sugar levels were too low. Staff told us they would offer people sweets and drinks which were stored in the medicines room. The manager and staff did not know sweets and drinks had run out and checks were not completed to make sure they were always available. The provider purchased stocks during our

inspection.

Staff knew about people's health care needs and some information was available for staff to refer to in people's care records. Community nurses visited daily to provide nursing care to some people, including the administration of injections. One person told us, "If I want anything staff act fast. The paramedics were called immediately for me this morning and staff kept an eye on my all the way through just in case I needed them and a friendly face". We observed that the staff called paramedics immediately the person told them they felt unwell. This information was also shared with the person's nurse when they called to administer flu vaccinations, Other peoples' comments included, "The doctor comes here to see me whenever necessary and he organises it with the staff for when he needs to visit" and "The optician comes to see me once a year and I don't even have to leave my chair".

People were supported by staff or relatives 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.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us most of the staff were caring, their comments included: "The staff are very, very nice, especially the ones who have been here a long time", "The staff are angels they really are and every one of them knows what to do", "I couldn't wish for better staff, they're like family. I can laugh and joke with them or say anything I like and they all chat along" and "The staff are all good, I couldn't complain about any of them, they are all simply top class as long it is not at night". However we found that staff were not consistently caring.

At our last inspection we observed staff did not always respond to requests people made, such as for a drink of milk. At this inspection we observed the same person ask for a drink of milk and again staff did not respond to their request and they did not receive the drink they requested. Improvements had been made in the way people's hot drinks were served and staff no longer added milk and sugar to people's drinks without asking about their preferences.

People and their relatives were not fully involved in planning the service they received, including how their spiritual needs were met. One person told us, "I would like to watch 'Songs of Praise' but I can never work out what time it is on and the staff are always too busy to let me know". The person had not watched Songs of Praise when they wanted to. Other people said, "We don't have a church service as such here but the priest comes to me for communion, my friend is Catholic so they have their communion separately". One person's relative told us, "Although I feel communication (from the manager) has improved, I do feel that I am told things on a 'need-to-know' basis". People's relatives told us they were free to visit their relatives when they wanted and went out with their relatives when they could.

A member of staff had been employed to plan the redecoration of the bedrooms and communal areas. People had not been involved in planning the redecoration and had not been asked for their views and ideas. One person told us they did not like the new chairs because "I keep slipping out of them". Staff told us people had not had the opportunity to try to chairs before they were purchased to check that they were comfortable and met their needs.

Bedrooms which were not being used had been decorated but people's bedrooms had not. The person planning the redecoration had purchased new bedding, furniture and lighting and showed it to us. The provider told us two people had been involved in planning the redecoration of their bedroom, however the redecoration not taken place at the time of our inspection. Plans were in place to move people to newly decorated rooms temporarily whilst their bedrooms were being decorated. People and their relatives had not been involved in making the decision and the person doing the redecoration told us plans were not in place to do this. One person had recently moved bedroom so staff could monitor them more closely. The person told us, "I brought my own bits of furniture from home but I have had to move room and this one is much smaller so I have had to leave some of my things in the old room". The person was not happy about this.

Information about people's life history continued to be limited. This information helps staff get to know

people and provide their care in the way they prefer. Action had not been taken to use information available to support people to be involved in the service. One person chatted to us about their life before they moved into the service at this inspection and the last inspection. This information was not included in their records, however staff knew about it. At our last inspection we discussed making contacting organisations who could support the person to reminisce about their experiences. The person told staff and us they would like to do this. At this inspection we found that action had not been taken to support the person to contact organisations who could help. The person told us they were disappointed about this. Another person's records showed they had experience of painting and decorating. Staff had not spoken to them about the redecoration of the building or invited them to be involved.

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 and staff were not always clear in the ways they spoke to people. At 11am we observed the staff member responsible for redecorating, ask a person living with dementia if they would like to "come and see the sunset". The person appeared confused by this request as the sun was not setting at this time.

Staff only interacted with people with complex needs to provide basic care such as offering them a drink or meal. We observed that in 30 minutes, two people living with dementia received one brief interaction from staff. These people continued to be at risk of being isolated. One person told us, "I do get a bit bored and lonely".

The provider had failed to provide care to reflect people's preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they continued to have privacy. Their comments included, "I get all the privacy I want" and "I get privacy alright, sometimes I'd say too much and I don't see a soul". Staff offered people assistance discreetly without being intrusive. They made sure that doors and curtains were closed and people were covered when they provided their personal care.

Previously people told us that staff did not respect their wishes and rushed them at times. At this inspection people told us staff now listened to them and they were not rushed. People told us, "I don't get rushed or pushed to do anything I am not happy with the staff are always patient with me, kind gentle, helpful and most understanding" and "I can take all the time I need, I never get rushed or hurried because the girls all know that would fluster me".

People appeared relaxed in each other's company and the company of staff. Most staff showed an interest in people and people responded to them. One person told us, "It can be a bit awkward sometimes with personal care but they've got it down to a fine art now and we don't take any notice of what's going on and just chat over it". Another people said, "Most of the staff are all very thoughtful and will bring me a little something to cheer me up if I'm feeling low, just a magazine or something like that", "I would tell the girls anything if I was worried they always know just what to do for the best" and "I get an answer immediately if we have a concern about anything I are not left to worry".

At previous inspections we found that personal, confidential information about people and their needs was not kept consistently safe and secure. Action had been taken to address this and information about people was no longer stored in communal records. However, information was not always stored securely and we found one person's records in another person's bedroom.

The service closed following our inspection. People who needed support to share their views about where

they wanted to move to were supported by their families or their care manager.

Inadequate

Is the service responsive?

Our findings

At our last two inspections we found that people's needs had not been consistently assessed and their care had not been planned with them. At this inspection we found that people's care plans had been rewritten but did not contain all the information staff needed to provide their care. One person told us, "When I'm in my room I can't reach certain things, so staff always make sure everything I need is within reach, unless it is temporary staff and then they forget I don't think it's written down". We reviewed the person's records and found this information was not recorded in their care plan.

The manager and a manager from another service had reviewed and rewritten people's care plans in July and August 2017. These reviews were not completed with people and their relatives. Care plans had improved and included more information about people's needs. The provider's action plan dated 3 October stated 'Care Plans are being fully reviewed'. However we found that checks on care plan reviews had not been effective and people's care plans had not been regularly reviewed to ensure they reflected their current needs. The care plans we view were last reviewed in August 2017. Changes in the support people received had not been included in their care plan.

One person's care plan written in August 2017 stated that the person had been referred to a dietician. The person had met with a dietician in September 2017 and had been prescribed food supplements to help them gain weight. Their care plan had not been reviewed since 22 August 2017 and the guidance from the dietician had not been included. The manager told us the person had the supplements once a day but staff we spoke with were not sure how often the person had the supplements. There was a risk that the person would not receive the care they needed.

Another person had a new recliner chair with 'built in' pressure relieving equipment. The person's skin integrity care plan had not been reviewed and amended since the new equipment was received in September 2017. Guidance had not been provided to staff about how to use the chair to support the person to maintain their skin health. There was a risk that the person would not receive the support they needed to remain safe and comfortable in the way they preferred.

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

Previously we found people's moving and handling care plans did not contain guidance for staff about how to move people safely. Since the last inspection occupational therapists from the local authority had assessed people's needs and provided guidance about the equipment and techniques to move people safely. This was included in people's care records. We observed people being moved safely following the guidance provided by the occupational therapists.

An activities coordinator continued to work at the service. However, some people continued not to be supported to take part in activities and pastimes they enjoyed. People's comments included, "I would like to

play cards but there is no one to play with and I wouldn't say no to a nice magazine now and again but we don't get any", "I do get a bit bored and lonely and don't always want to join in with the rowdy lot", "I like a good game of cards but all we seem to do is hit balls around and look at pictures" and "I like to do puzzles and be quiet, there is not a lot else going on that I fancy joining in with. It's a bit loud and boisterous for me all that bashing a ball about".

People were not involved in planning the activities that took place at the service. We would expect staff to ask people about their social interests and leisure activities and plan a programme to support people to continue to participate in these. Some people had not been asked about this and information about other people was incorrect. For example, one person's care plan said they like to watch television and listen to the radio in their bedroom. We met the person in their room; they did not have a television and told us they did not like to watch TV. They had a radio but said they didn't listen to it and preferred to do other things. Staff confirmed that the person did not like the radio on.

We observed some people taking part in activities with the activities coordinator, including ball games and a quiz. The people who took part in these activities told us they enjoyed them. Other people, some of who were living with dementia were not supported to take part in hobbies and activities they enjoyed. The activities coordinator had not been supported to develop their skills in providing activities for people with dementia. During our inspection the manager asked them to support one person living with dementia to go out. They said that they did not feel confident to do this as the person had been reluctant to return previously and they did not have the skills to support the person.

The provider had failed to ensure that people's care was designed to reflect their preferences and ensure their hobbies and interests were supported. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Previously we found the provider had failed to operate an effective and accessible complaints system. There had been some improvement made to the process but these were not followed consistently. One person's relative told us they felt their complaint had not been resolved to their satisfaction and they were not confident to raise concerns with the provider because they had failed to act on previous complaints. Complaints the relative had made had not been addressed previously and were investigated by the local authority safeguarding team and abuse was confirmed.

People told us they would speak with staff if they had a concern or a complaint and that they would be listened to. They said they would prefer to speak with staff as they did not have confidence that the manager or provider would take action. Staff told us they would take action to resolve people's concerns where they could but were not confident to raise concerns with the manager because they felt they would be blamed. One person told us, "If I'm worried about anything at all I just have a chat with the girls and they are always willing to help but I would not go to the manager because she can be snappy".

A new complaints process to receive and respond to complaints was in place. A notice explaining how to complain was in the entrance area. People had still not been given information on how to complain in a format that was meaningful to them, for example using pictures or larger print. There continued to be a risk that some people would not know how make complaints about the service they received.

When some complaints had been made the action taken to investigate and resolve them had been recorded. The manager told us they completed a monthly audit of these to look for themes. However these was no evidence the manager had looked for themes as they had only noted the number of concerns or complaints; it did not check for or identify any patterns or emerging trends.

The provider had failed to operate an effective and accessible system to identify, receive, record, handle and respond to complaints by service users and other people. This was a continued breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The manager had been working at the service since June 2017. A registered manager had not been working at the service since May 2015. The manager had applied to be registered by the Care Quality Commission (CQC). They withdrew this application following our inspection. There had been three managers at the service since May 2015 and the long term lack of consistent leadership had impacted on all areas of the service. One staff member told us, "We've not had any effectual leadership for some time".

There was not an open culture at the service where people, their relatives and staff were empowered to be involved in improving the service. The provider told us "The staff are unmanageable". The manager said, "With some staff we will never be able to get them on-board. They are not happy with the changes that are happening – sticking to the rules and regulations. Things are much stricter now". The manager had arranged staff meetings and told us "I have introduced employee of the month sweeties and a raffle at the staff meeting to get them (staff) to attend". This had not increased attendance at staff meetings and the last meeting had only four attendees out of 23 staff.

The provider had completed a check of the service in August 2017 but had not identified the concerns raised with them by staff and the manager. Action had not been taken to understand and resolve the staff culture issues and develop a supportive working relationship between staff.

Staff told us they did not receive constructive feedback from the provider and did not feel valued or appreciated. They told us they did not receive praise and encouragement but were "constantly criticized" and "The manager seems to pick on all of long standing staff, nit picking". The manager told us that staff were 'not on board' with the changes they had implemented. One staff member told us they hid from the manager as they felt that the manager 'told them off' every time they spoke to them. All the staff we spoke with said they were looking for other jobs and planned to leave Fourwinds Residential Care Home.

People and their relatives had recognised and were concerned about the changes in the culture at the service and that the relationship between the manager and most of the staff was not positive. People's comments included, "The manager is a bit snappy, I have to say they are not a good manager and are rude", "I would not go to the manager, they are not a good manager as far as I am concerned, they rule with fear not leadership" and "Sometimes I can hear or see [the manager] snapping at the girls for no reason at all, they might just be having a chat with me and sharing a biscuit but then get shouted at and told not to eat at work when they were just keeping me company. You don't shout at your 'men' in front of the troops it's bad for morale". One person's relative said, "Staff seem petrified of [the manager] and raising issues with her. They have mentioned they are afraid of receiving a 'disciplinary". The manager and provider told us they had not asked people about the culture at the service and were not aware of people's views and did not respond when we told them what people had said.

There had been a further change in the support staff received from the manager to complete routine tasks. One previous manager had delegated lots of tasks to staff reducing the amount of time available to provide

people's care. Another previous manager had taken back some tasks such as administering medicines. The task of administering medicines had been delegated back to staff by the current manager and all staff had been required to complete medicines training. Staff were unclear about their role as they said the change had not been communicated effectively, for example at team meetings and one to one meetings. The minutes of the August 2017 staff meeting state 'all staff must be trained in medication' but did not give an explanation about why this was required. Only six of the 22 staff had attended the meeting. The manager told us staff were required to sign the minutes to confirm they had read them. Only ten staff had done this. Care staff told us they did not know why they were now required to complete the training and administer medicines as previously this role had been undertaken by the manager and senior care staff only.

Staff continued not to receive feedback about their performance to develop their skills. The lack of one to one meetings between the manager and staff continued. Checks were not completed to make sure staff had the skills, knowledge and confidence to complete tasks. For example, some staff told us they did not feel confident to administer medicines safely. Their competence had not been assessed and they said that they had not received support from the manager when they had raised their concerns. The manager confirmed they had not discussed staff's concerns with them and staff continued to lack confidence in their ability to administer medicines safely.

At the last inspection we found that the provider had not put systems in place to support the manager. This continued and the manager told us they did not feel supported by the provider to make the changes required to improve the quality of the service. Consultants employed by the provider had identified this and noted it in the action plan they had given to the provider. Their comments included, 'New Manager although supported by [other consultant], is not being supported fully at present' and 'Manager needs autonomy in dealing with staff issues and support from [provider] to do so'. The provider told us that they had arranged support for the manager from registered managers of two other services they owned, an administrator and consultants. The provider felt that he had given the manager all the support they needed to improve the service and had not recognised that they had not supported the manager to develop and build team working.

A consultant had been employed for three months starting in September 2017 to 'update general documentation' and 'be involved with competencies of staff'. They had observed a mealtime on 3 October 2017. During their observation they had asked the cook the temperature of the food before it was served. The consultants notes of the observation stated the cook had told them they had '"Forgotten to do (check) it", shrugged and walked away. Did not seem to recognise the importance of recording'. The consultant also highlighted other areas of poor practice during their observations. For example, the beef was reported by several people as being chewy, tables were being laid up for the next meal as people left the table and 'no real cleaning of tables took place' and that there was little involvement or interaction from some staff. No action had been taken to address these shortfalls.

The provider had not taken action since our last inspection to share a clear vision of the service with staff and the manager. Staff were unable to tell us the standards to which the service should be provided and staff continued to provide care to their own standards. These were lower than the standards some people and their families expected, for example having their bedroom the temperature they preferred. Values including individual led care continued not to underpin the service provided to people each day. There was a 'blame' culture at the service and the provider and manager blamed people and staff for the shortfalls we found during our inspection including the shortfalls in the management of medicines. We spoke with the provider and manager about the risks of one person choking. The manager said, "They chose the wrong food". The provider said, "I've told them if they don't sit in the dining room staff can't monitor them". The manager had assessed the person had capacity to decide what they ate however the person had not been

given safe options to choose between. The provider did not understand they were responsible for keeping people safe at all times, while respecting the choices and decisions.

The provider continued not to ensure people were fully involved in developing service and the 'regular service users meetings' described in their statement of purpose were not held. People told us they were not involved in the day to day decisions about the service. Their comments included, "I've been to one or two residents meetings but they are few and far between", "We don't have too many residents meetings. I think there have only been two", "We do make suggestions about this and that and the girls do listen, but what can they do? Their hands are tied and management won't listen" and "We can decide when we want to get up and come down but that is about the full extent of our input".

People, their relatives and health professionals had been asked for their opinions of the service in since our last inspection, this was an improvement from our previous inspection. People's comments included, "I feel rushed in the morning" "More food variety" and "Would like to sit in the garden when the sun is out". People had taken time to share their experiences; however there was no record of what action the provider had been taken to ensure everyone's opinions were valued and their concerns were addressed. We asked the provider what action they had taken to address people's concerns and they did not respond.

Previously people and their relatives told us that mealtimes were too close together during the day and there was a thirteen hour gap between supper and breakfast and sometime they felt hungry. The provider had not reviewed the meal times and acted on people's feedback, they were not able to explain to us why they had not reviewed this.

Staff told us they had not been supported and encouraged to share their views about the service. Three staff meetings had been held since the manager began working at the service in June 2017. The meetings were not well attended despite attendance being compulsory. Minutes of the meetings did not show that staff had been asked for their views of the service. Other ways of obtaining staffs views or suggestions about how the service could be improved had not been considered.

The provider had not taken action since our last inspection to gain an oversight of the service. They had employed a consultant to develop an improvement action plan which 'takes into account internal audits'. The provider had completed just one check on the service since our last inspection. Their report included an overview that staff morale was good and included staff's the views of a previous manager. It did not include detail of the staff working relationship with the new manager even though they had been working at the service for two months.

The provider's action plan of October 2017 stated 'internal audits are ongoing' and 'continuous audit is in place in order to keep the action plan updated'. However, we found audits had not been completed and the provider told us they were unaware of this. The last internal medicines audit had been completed in August 2017. The manager told us they had concerns about the practice of a staff member managing medicines at this time and had requested the pharmacy complete an audit which had not found any shortfalls. The provider had not completed their own audits to make sure medicines were managed in line with the provider's policies and poor practice continued.

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, about the services provided to continually evaluate and improve the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records about each person's care and support had improved but were not consistently accurate and complete. This included medicine records and information about people. Care plan records were used by new and agency staff to obtain information about people and there was a risk that information available to them would not reflect people's needs and wishes.

The manager had not recorded the date they had completed many records, including people's care plans, risk assessments and reviews. They had recorded the month and the year but not the day. It was not possible for staff and visiting health care professionals to make sure they were using the most up to date information.

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

Services that provide health and social care to people are required to inform CQC of important events that happen in the service like a serious injury or deprivation of liberty safeguards (DoLS)authorisation without delay. This is so we can check that appropriate action had been taken. There had been four DoLS authorisation granted in September 2017 that had not been reported to the CQC. The manager told us they knew that they needed to notify CQC of these authorisations but said they had not had time to do this.

The provider had failed to notify the Commission without delay when Deprivation of Liberty Safeguards authorisation were granted. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Registered providers are required to display the most recent rating of their performance by the CQC conspicuously at the service and on any websites maintained for or by them. At our previous inspections we found the provider had not displayed the most recent performance rating at the service or on their website. At this inspection we found that a copy of the provider's most recent rating was displayed in the entrance hall. They had taken down their website.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Commission without delay when deprivation of liberty safeguards authorisation were granted.

The enforcement action we took:

We cancelled the provider's registration for this location.

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 provide care to reflect people's preferences. The provider had failed to consistently plan people's care, with a view to achieving peoples' preferences and ensuring their needs were met. The provider had failed to ensure that people's care was designed to reflect their preferences and ensure their hobbies and interests were supported.

The enforcement action we took:

We cancelled the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to act in accordance with the Mental Capacity Act 2005. The provider had restricted people's liberty of movement.

The enforcement action we took:

We cancelled the provider's registration for this location.

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 consistently reduce the risks to people's health and safety and take action to manage risks. The provider had failed to operate proper and safe medicines management processes in relation to the ordering, storage, disposal and recording of medicines.

The enforcement action we took:

We cancelled the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to operate an effective and accessible system to identify, receive, record, handle and respond to complaints by service users and other people.

The enforcement action we took:

We cancelled the provider's registration for this location.

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 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, about the services provided to continually evaluate and improve the service. 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 enforcement action we took:

We cancelled the provider's registration for this location.

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 skilled and experienced 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 cancelled the provider's registration for this location.