Networking Care Partnerships (South West) Limited

1-4 Windsor Drive

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection took place on 12 and 13 March 2018 and the first day was unannounced. We last inspected this service in December 2016 where it was rated 'Requires Improvement' overall and 'Requires Improvement' in the Safe, Caring, Responsive and Well-led key questions. Following this previous inspection in December 2016 we identified four breaches of regulation, corresponding to regulation 9, person-centred care, regulation 10, dignity and respect, regulation 17, good governance and regulation 18, staffing.

Following our inspection in December 2016 we asked the provider to complete an action plan to show what they would do and by when to improve the key questions Safe, Caring, Responsive and Well-led to at least a 'good'. We found that although action had been taken this was not sufficient to improve the ratings at the service or to meet the requirements set by the breaches of regulation.

1-4 Windsor Drive is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. 1-4 Windsor Drive is registered to accommodate up to 12 people with learning disabilities and complex needs across four separate bungalows, each of which has separate adapted facilities. At the time of this inspection in March 2018 there were eight people living at the service, spread across all four bungalows.

The service was not developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. We found these were not shared by the service.

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

During our previous inspection in December 2016 we identified four breaches of regulation, relating to people not receiving care which always met their needs, people's lack of opportunities to spend time outside the service, staff failing to demonstrate respect towards some people, insufficient staffing numbers to meet people's needs and ineffective systems in place to monitor and improve the service. During this inspection we found three of these areas still required improvements and three regulations were still in breach. We also identified two further breaches of regulation and new concerns.

People who lived in 1-4 Windsor Drive were not always safe. Although we saw a number of good examples of risks to people being identified, reported and well managed, we also identified instances where risks had not been adequately assessed or mitigated. For example, staff did not have any information relating to the acceptable blood sugar levels for one person living with diabetes. Although staff were regularly checking the

person's levels they did not know what these should be, how they presented should their levels be too low or too high or what they should do in these instances. We also found risks relating to one person's meals containing items identified as being high risk for them by a specialist speech and language therapist. This placed this person at risk of choking.

All the people living in the service required help to take their medicines. Prior to our inspection a medicine error had taken place and the registered manager had assured us they had reviewed systems for medicine management in order to ensure risks of reoccurrence were minimised. We found, however, when reviewing people's medicines, that the systems in place to record and review medicines did not make it possible for the staff or registered manager to ensure people were taking their medicines as required. We found a number of inconsistencies between the number of tablets people had in stock compared to the numbers recorded. This meant it was not possible to tell whether people had been taking their medicines as prescribed by their doctor.

We identified some concerns relating to the five principles of the Mental Capacity Act 2005 (MCA) which include that any action taken on a person's behalf must be in their best interests and regard must be had as to whether an act or decision is the least restrictive of a person's rights and freedoms. We found one person's privacy was potentially being violated by staff who used a viewing hole in their bedroom door to look in on them when there was no clear reason for doing so. We also found one person's money had been used to purchase some equipment which was going to be used to equip the service's sensory room. Although the person was likely to benefit from this, all other people living in the service would be able to use this and this had not been discussed with the person or taken into account when making the decision.

People did not have access to sufficient opportunities to leave the service, to socialise or take part in activities that met their individual needs and interests. One person shared their experience with their relative and said, "I've lived a quiet life for seven years and I've had enough and want to get out and about more". People, staff and relatives confirmed people did not regularly take part in activities outside of the home and told us this was down to shortages of staffing numbers and access to vehicles. Although some staff told us they felt supported to carry out their work, others told us they did not feel this way. We found staff supervisions were not being carried out regularly. The registered manager told us they were working towards improving this.

People had access to sufficient amounts of food and drinks to meet their health needs by staff who knew how best to encourage them and support them. However, we found risks relating to the foods being eaten by one person and found that people were not being encouraged to take part in the preparation of food. Staff did not work towards involving people in the running of the home by joining in with daily tasks where they could. Improvements were required in relation to providing people with accessible information in order to best communicate their care plans, assessments and personal information to them.

Although we observed some very positive interactions between staff and people, and it was clear staff knew people very well, we witnessed an incident which did not demonstrate respect towards one person. One member of staff did not demonstrate respect of one person's dignity or privacy by opening and leaving open, the person's bedroom door, when they were in a state of undress.

The systems in place to assess and monitor the quality and safety of the service had not been effective in identifying some of the concerns we found during this inspection. Although concerns had been raised during the previous inspection, inadequate efforts had been made to improve in those areas.

We found records for people were not always accurate and were sometimes not personalised. For example,

people were put on fluid output charts whether this was required or not. People's care plans were highly detailed however, and contained lots of clear guidance and information for staff on how to best support people.

People's bedrooms were personalised to reflect their preferences and their personalities.

Staff were provided with training to meet people's needs. Training topics included supporting people with epilepsy, autism and mental health needs, medicine administration, food hygiene, first aid, fire awareness and more. Staff knew how to recognise signs of potential abuse and knew how to report any concerns they may have. Recruitment practices at the service ensured that, as far as possible, only suitable staff were employed.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to people's individual needs not being met, people's rights under the MCA not being protected, people not always being safe from risks relating to their health and to medicines, staff numbers not being adequate to meet people's needs and staff not being supported, and ineffective quality assurance systems. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The systems in place to manage medicines did not ensure people had their medicines as prescribed.

Risks to people had not always been mitigated.

People were protected from the risk of abuse as staff understood the signs of abuse and how to raise concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights were not always respected under the Mental Capacity Act 2005.

Not all staff felt supported and regular supervisions were not taking place.

Staff were provided with training and understood people's individual needs.

People had enough to eat and drink to meet their health needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always show respect for one person's dignity and privacy.

We observed some highly positive interactions between staff and people.

Staff knew people well and could clearly communicate with people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's social needs were not being met and they did not have sufficient opportunities to leave the service or take part in meaningful activities.

Care was not always person centred and effort was not made to include people in the daily running of the service.

Improvements were required in relation to providing people with accessible communication.

Relatives told us they felt comfortable making complaints and records showed where these had been made these had been dealt with.

Is the service well-led?

Inadequate

The service was not well led.

Insufficient improvements had been made following our previous inspection and all regulations previously breached in December 2016 were still in breach.

There were systems in place to assess and monitor the safety and quality of care provided but these had failed to identify concerns raised in this inspection.

There were mixed views amongst staff regarding the approachability and supportive nature of the management. Relatives spoke highly of the management and told us they felt confidence in them.

1-4 Windsor Drive

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 12 and 13 March 2018 and the first day was unannounced. One adult social care inspector carried out this inspection. Prior to the inspection we reviewed the information we had about the service, including notifications of events the service is required by law to send us.

Most people who lived in 1-4 Windsor Drive were unable to talk to us about their experience of the service because they had communication difficulties. Where people were able to share their experiences with us we spent time speaking with them but where they were not we used the principles of SOFI to aid our observations. SOFI (Short Observational Framework for Inspection) is a specific way of observing care to help us understand the experience of people who are unable to talk to us. Due to people spending most of their time in different rooms, different bungalows and going about their day, it was not possible for us to conduct a complete SOFI but we did use the principles of SOFI when conducting all our observations around the home.

We looked around the four bungalows, spent time with people in the different bungalows, kitchens and lounges and looked at people's rooms with their permission. We observed how staff interacted with people throughout the inspection and spent time with people over the breakfast and lunchtime periods on both days. We spent time speaking with two people who were able to share their experiences with us and spent time observing all the other people who lived in the home being supported by staff. We spoke in depth with seven members of staff, one relative, one visiting healthcare professional, the registered manager and one of the directors. We also received feedback from two external healthcare professionals.

We looked at the ways in which medicines were recorded, stored and administered to people. We also looked at the way in which meals were prepared and served and reviewed in detail the care provided to four people, looking at their care files and other records. We reviewed the recruitment files for four staff members and other records relating to the operation of the service, such as risk assessments, complaints, accidents

and incidents, policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Following our previous inspection in December 2016 this key question had been rated as 'Requires Improvement'. This was because we had identified concerns relating to the staffing numbers available at the service. At this inspection we found that concerns were still present in relation to the staffing numbers but felt this evidence was better suited under the key question of Responsive. With regards to the Safe key question we identified further concerns relating to people's safety.

During this inspection, in March 2018, we found people who lived in 1-4 Windsor Drive were not always safe. All the people who lived in 1-4 Windsor Drive needed help from staff to take their medicines. Although staff were knowledgeable about people's medicines and had received training and observations, we found inconsistencies in the medicine stock. Each person's medicines were kept within a safe in their bedroom and staff told us they regularly conducted audits and checks to ensure medicines were recorded and administered correctly. In the month prior to our inspection a medicine error had occurred whereby a person had missed taking their medicines. Staff had taken action to respond to this. We found, however, when we looked at four people's medicines, that there were inconsistencies in numbers for each person. The numbers of tablets recorded on people's individual medicine administration record sheets did not correspond to the numbers of physical tablets present within their personal safe. At times the numbers in the safe were too high and sometimes they were too low. This meant the provider could not assure themselves that people were receiving their medicines as prescribed by their doctor and could therefore placed people at risk of harm.

People were not always protected from the risk of harm relating to their conditions. Although we found some very clear examples where risks to people had been identified, action had been taken and staff had been given clear guidance on how to minimise risks, we found this was not always the case. Where one person had been diagnosed with type two diabetes, their care plan instructed staff to monitor this person's blood sugars twice a day. We looked at the recordings for this person's blood sugar levels and found a number of instances where this had not been checked and recorded twice a day and on occasion not been checked or recorded at all. We did not find any record of this person's acceptable blood sugar range or what staff should do should the person fall outside of this range. Staff told us they did not know what this person's normal range was or have guidance to follow should their blood sugar level be too high or too low. We spoke with the registered manager about this and they told us the doctor had told them regular checks of this person's blood sugars were not necessary. They also said they checked them anyway as they believed that should the person's levels get too low then this could lead them to have epileptic seizures. They told us they believed the person's blood sugar levels should be between eight and twelve mmols (a measure to quantify sugar levels in the blood). Records showed that in the past month the person's blood sugar levels had varied greatly between 7.9mmols and 20mmols. Staff had not taken any action to respond to these levels. This could potentially have placed this person at risk.

Some people had specific needs relating to their foods and fluids, for instance, some people needed their fluids thickened or their foods chopped up into small pieces. Where this was the case we found staff had sought guidance from specialist speech and language therapists. We found, however, that guidance in

people's care plans was not always clear and at times people's diet did not follow the specialist guidance obtained. For example, one person had been assessed as being at risk of choking and staff had been advised to avoid giving them certain at 'risk' foods. When looking at this person's food chart we found they regularly ate a number of the foods the specialist had advised against. We spoke about this with the registered manager who told us the person enjoyed those foods but confirmed they had not spoken to the person about the specific risks associated with those foods or completed a best interest decision around them. This could have placed this person at risk of choking.

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

Most people who lived in 1-4 Windsor Drive were unable to tell us whether they felt safe at the service. Where people were able to share their views with us they confirmed they did feel safe. During our inspection we spent time observing people's interactions with staff. We saw people spending time with staff, reaching out to them, smiling and looking comfortable in their presence. This indicated to us that people felt safe in staff's company. Recruitment practices at the service ensured that, as far as possible, only suitable staff were employed. Staff files showed the relevant checks had been completed. This included a disclosure and barring service check (police record check). Proof of identity and references were obtained as well as full employment histories, this protected people from the risks associated with employing unsuitable staff. Staff numbers were sufficient to ensure people were safe from risks but were not sufficient to meet their needs. We have explored this in more detail within the Responsive key question.

People were protected by staff who knew how to recognise signs of potential abuse. Staff confirmed they knew how to identify and report any concerns. Staff had received training in how to recognise signs of harm or abuse and knew where to access the information if they needed it. Safeguarding information and relevant contact numbers were displayed within the bungalows for them to use. Staff were encouraged to speak about safeguarding and we saw this had been discussed during a new starter's supervision meeting.

People had a variety of needs relating to their learning disability, autism spectrum disorder and physical health. These included needs relating to people's epilepsy. We found staff had created highly detailed assessments and had put clear plans in place for staff to follow in relation to people's epilepsy. Staff had received specialised training in this area in order to be able to safely meet these specific healthcare needs. The guidance described how each person who lived with epilepsy exhibited their seizures, what signs staff were to look for and what actions they should take. Relevant monitoring and protecting equipment, such as bed and audio monitors had been purchased following best interest decisions.

The premises and the equipment were well maintained to ensure people were kept safe. Regular checks were undertaken in relation to the environment and the maintenance and safety of equipment. Good infection control practices were in use and there were specific infection control measures used in the kitchens, the laundry rooms and in the delivery of people's personal care. The bungalows had fire extinguishers, fire protection equipment and clearly signposted fire exits to assist people in the event of a fire. Each person had a completed personal emergency evacuation plan which detailed how they needed to be supported in the event of an emergency evacuation from the building.

Where accidents and incidents had taken place, the registered manager had reviewed these to ensure risks to people were minimised. We found examples where actions had been taken to ensure accidents and incidents did not reoccur. However, where an incident had taken place involving a person missing their medicines, we found sufficient action had not been taken to minimise risks of reoccurrence as we identified a number of errors within the medicine stocks and records. The registered manager told us they would be

taking immediate action to review people's medicines and ensure risks were minimised.

Requires Improvement

Is the service effective?

Our findings

Following our previous inspection in December 2016 this key question had been rated 'Good'.

During this inspection in March 2018 we identified some concerns relating to the Mental Capacity Act 2005 which could have resulted in people potentially having their rights restricted.

The people who lived in 1-4 Windsor Drive had a variety of needs, with some people living with forms of cognitive impairments which could affect their ability to make decisions. We therefore checked whether 1-4 Windsor Drive was working within the principles of The Mental Capacity Act 2005 (MCA). 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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We identified some concerns relating to two people who had been unable to make certain decisions themselves and who had decisions made for them under the best interest process and the deprivation of liberty safeguards process. The best interest process relates to the five statutory principles of the MCA which include that all individuals are presumed to have capacity; an action taken on behalf of a person must be in their best interests and regard must be had as to whether an act or decision is the least restrictive of a person's rights and freedoms. Where a person is assessed as not having capacity to make a specific decision, a decision can be made for them as long as this is in their best interest. We found clear evidence that the best interest process had been followed where people had been unable to make their own decisions. We did, however, identify one decision which was made on behalf of a person which caused us concern. This related to a person purchasing sensory equipment. Staff informed us this equipment had been purchased in order to equip the sensory room which was being refurbished in one of the bungalows. The registered manager informed us this equipment was purchased specifically for this person. However, we found that all other people living in 1-4 Windsor Drive would also have access to it and to the equipment. The nature of the use of the equipment had not been made clear when making the best interest decision for this person and we therefore shared our concerns about this with the local safeguarding team.

Another concern we had related to a person who had a DoLS in place. 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). This had been applied for and granted and related to the person being under constant supervision, not being able to leave the service unescorted and having a viewing hole in their bedroom door. The DoLS authorisation made it clear this viewing hole had been installed and was only to be used in order to observe the person eating as they were at risk of choking and refused to eat in the company of others or under staff supervision. We found, however, that a speech and language therapist assessment had concluded the person had no specific needs relating to their swallowing or were at a choking risk. We also found the viewing hole was being used by staff at other times, when the person was not eating. For instance, two weeks prior to our inspection, staff had recorded they had used the viewing

hole to look in on the person 12 times between 10.30pm and 7am. We also found the viewing hole open when we visited the person's bungalow at 11.30am on the second day of our inspection although they were not eating anything at the time. Using this viewing hole in this person's door without a clear reason could be a violation of their privacy and a violation of the five principles of the MCA which state that any decision made on someone's behalf must be the least restrictive possible.

This was a breach of regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff gave differing views on whether they felt supported by the management, with some being very positive and others very negative. Some staff felt very comfortable sharing their views with us and others told us they had been asked by other staff not to speak up. The registered manager told us they led monthly group supervisions with staff and individual supervisions every three months. We looked at four staff files and found only one example of an individual supervision. This was a comprehensive supervision where the staff member was encouraged to share their views, any concerns they may have and had their knowledge checked. However, it was the only one we found despite some of the staff whose files we looked at had worked for the service for a number of years. One staff member said "We get supervisions but not regularly", another said "I have not had supervision in ages". We spoke about this with the registered manager who told us they were making changes to improve the supervision system and they told us some supervision records were stored elsewhere. We asked the registered manager to send us copies of these in the week following our inspection but we did not receive any.

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

A training programme ensured staff received the training necessary for their role. Staff spoke highly of the training they received and told us they could always request further training if they wanted or needed it. Comments from staff included "If I wanted more training I could get it" and "I have had all the training. If you want more training just ask and they will give you more". The staff training programme included some face-to-face training as well as some eLearning. Training included topics relating to people's specific care needs, such as supporting people with epilepsy, autism and mental health needs, as well as medicines administration, food hygiene, first aid, fire awareness, health and safety, safeguarding and moving and transferring. The registered manager told us new staff completed the service's induction programme, and for those who were employed with no previous care experience, they would also undertake the care certificate. The care certificate is an identified set of standards used by the care industry to ensure staff provide compassionate, safe and high quality care and support.

People were supported to have enough to eat and drink. During our inspection we observed people eating their breakfast and lunchtime meals on both days. Staff prepared people's meals according to a set menu and presented it in ways that met people's specific needs, using specific crockery. We observed staff prepare people's meals without involving them in the process. We asked staff whether people helped in the kitchen and they told us that occasionally they did but that they were more of a "hindrance than a help". Another member of staff said "People are not involved much. We just get on and do things. There's a lot more that could be done here". This was not inclusive and did not encourage people's independence, improve their skills, involve people in the running of their home or act as entertainment or activity for people. We did find that staff were very supportive of people when helping them eat their meals and used innovative ways of encouraging people to eat more. For example, one person loved having their stuffed animals with them and we saw one staff member using these as a way to encourage the person to eat. Records indicated that people were maintaining their weight and eating and drinking well. Where they weren't we saw staff had

sought help from external professionals.

People were supported by staff to see healthcare professionals such as GPs, specialist nurses, neurologists, psychologists, district nurses, occupational health practitioners, opticians and dentists. We found examples of staff identifying concerns or changes in people's needs, raising this with outside professionals and following their guidance. We received feedback from two external professionals who had dealings with the service and they told us they had no concerns and felt staff knew people well.

The environment at 1-4 Windsor Drive was comfortable and sociable. The bungalows were set close to each other and people could move between them with support. The environment had been adapted to meet people's specific mobility needs. All areas were wheelchair accessible and where required, bathrooms had overhead tracking fitted to enable people's accessibility.

Requires Improvement

Is the service caring?

Our findings

Following our previous inspection in December 2016 this key question had been rated as 'Requires Improvement'. We had also found a breach of regulation because we had identified concerns relating to people's dignity and respect not always being upheld. At this inspection we found that, although we still had some concerns, sufficient actions had been taken to ensure the service no longer breached this regulation.

Almost all the interactions we observed between staff and people were respectful and caring. We did, on one occasion however, see a member of staff not demonstrating they understood the importance in ensuring a person's privacy and dignity by opening and leaving open, a person's bedroom door, when they were in a state of undress. We spoke with the registered manager about this issue and they told us they would speak with this member of staff and provide them with further training and support where required.

We saw people were mostly involved in their care although we found that opportunities to involve people in daily living, such as cooking, cleaning, doing the laundry etc were missed. We saw people making choices with regards to snacks and some activities but identified an instance where a person was not given the choice to express themselves as they wished. During the first day of our inspection we saw one person having their nails polished a bright purple colour. The person enjoyed this and showed off their nails to us with joy. A male person who lived in the service had been observing this person having their nails polished and communicated with body language that they wanted theirs painted also. A member of staff understood their demand and agreed to polish their nails but went to get a clear nail polish to do this and did not give the person the choice of colour. As they did this they said they were choosing a more 'appropriate' colour for them. Although the member of staff enabled the person to have nail polish as they had wanted, they did not offer them the opportunity to express themselves in the choice of colour and made assumptions based on their gender about the colour they would like. This did not demonstrate a clear understanding of equality and diversity. We fed this back to the registered manager who understood this and told us they would discuss this with staff.

During our inspection we observed some very positive, kind and caring interactions between staff and people. The atmosphere in the bungalows was warm and welcoming and it was clear people were comfortable in staff presence. Staff knew people very well and were able to communicate with them and joke with them. Staff made a number of comments to us which demonstrated how much they cared for people and enjoyed their personalities and individual attributes. For instance, where we spoke with a member of staff about a person's photograph the member of staff said "Isn't she beautiful". This was said in a way that demonstrated genuine affection towards that person.

People's bedrooms were personalised to meet their preferences and their taste. One person proudly showed us their bedroom and the decorations they had chosen. People's art work was displayed on the walls of the bungalows which made these look homely and increased people's pride in their work.

Requires Improvement

Is the service responsive?

Our findings

Following our inspection in December 2016 this key question had been rated as 'Requires Improvement'. We had identified a breach in regulation relating to some areas of people's care and support not being met. During this inspection we found not enough action had been taken to improve in these areas and therefore the same concerns remained and the regulation was still in breach.

There were not enough opportunities for people to go out of the service, to socialise or to take part in activities that met their social needs. Relatives and staff felt this was the case and we saw from records people did not have many opportunities to go out or to take part in interesting activities. Comments made by relatives included "He is always so happy when we take him out. He loves to go out but he doesn't get to much" and "(My relative) said just now "Worried about lack of staff", she wants to go out more. She doesn't because of staff and vehicles. She said "I've lived a quiet life for seven years and I've had enough and want to get out and about more". Staff told us there were insufficient staff to be able to take people out and that people were not encouraged to go out. Staff and relatives told us there was only one vehicle available which could only transport two people and not many staff members were trained to drive this vehicle. This meant that if a person needed to be taken to a medical appointment then there was no alternative transport to take anyone else out. People's care plans were very clear about their desires to go out and how not going out regularly could affect them and their behaviours. For example, one person's care plan made specific reference to them getting upset if they didn't get to go out and how this would impact on their behaviour. We looked at the daily records and the activity records for this person and found they had been out of the service on one occasion between 1 March and 12 March and this was to attend a neurology appointment at the hospital.

One person's relative told us their loved one had always loved attending a wheelchair dance group in Exeter but that they had not been able to go to this due to staffing issues. They had therefore organised through a separate organisation for their loved one to be collected and taken to this group twice a month.

The registered manager confirmed staffing issues had reduced people's abilities to go out in ways that met their social needs. Although there had been a recent increase in staffing hours available, these had not ensured people's needs were met. Staff told us that where people had been assessed as requiring two to one support from staff, these people rarely left their bungalow. They told us this was due to staffing issues. Where one person liked to have their bath early in the morning because they wanted this before their breakfast, staff rotas had not been organised in order to accommodate this. This meant the person regularly became hungry whilst waiting for their bath and therefore affected their mood and behaviours for the rest of the day.

This demonstrated that there were not sufficient staffing numbers to ensure people's needs were met.

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

Where people had not been able to go out of the service, efforts had not been made to make up for that lack of socialisation and community integration. People had not had their friends invited over, or events been put on to ensure people still had access to outside stimulation and the chance to meet new people. Creative measures had not been taken to ensure people had access to activities which met their preferences or their needs. Records showed people spent the majority of their time watching television. Staff told us, and the registered manager confirmed, that people were not encouraged to take part in activities around the house, such as helping with cooking meals or folding laundry.

During our inspection we saw people go out with staff and take part in some activities, such as nail polishing, colouring and looking at photographs. People went out to the shops, into the town of Dawlish and to a day centre service in Exeter. Staff told us that this was not usual activity and records confirmed this.

People's care and support was not always person centred. We found that people were routinely placed on fluid, food, output and stool charts whether this had been identified as being necessary or not.

Although it was clear staff knew people well and could communicate with them in ways they understood, we found improvements were required in relation to accessible information. Each person's care plan contained a front sheet which detailed people's communication methods and how best to speak with and understand people. These were very clear and enabled staff working with people to immediately be able to communicate with people. We did, however, find a lack of information for people in a format they could understand. People did not have care plans in formats they could understand, such as pictures or videos, and therefore did not have access to information about their own health and care in a personalised way.

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

Each person had a detailed care plan which gave staff important information about their individual needs. We reviewed four people's care plans and found these to be highly detailed and to contain clear information for staff to follow in order to provide people with the support they needed. People had comprehensive plans relating to their preferred routines and how staff should support them in specific tasks whilst enabling their independence. We did, however, find people's care plans contained a significant volume information at times, which meant we found inconsistencies within the records. This was due to repeated information.

A complaints policy was in place at the service. The registered manager told us they encouraged people, staff and relatives to make complaints should they wish to. Some staff told us they felt comfortable raising any concerns, others told us they did not feel these were listened to or kept confidential when needed. Relatives told us they felt able to make complaints and within the records we reviewed we found examples of complaints being made and action being taken to respond. For example, a relative had made a complaint about the appearance of the front garden and this had been listened to and acted on.

The service was able to support people should their health decline and they require 'end of life' care. The registered manager said they were supported by the community nurses to ensure people's care needs could be met. At the time of our inspection no person was receiving end of life care.

Inadequate

Is the service well-led?

Our findings

Following our inspection in December 2016 this key question was rated 'Requires Improvement' and a breach of regulation was identified. This was due to the systems in place for monitoring the quality and safety of the care provided at the service had been inadequate in identifying and responding to risks. At this inspection in March 2018 we found insufficient improvements had been made and the service was still in breach of this regulation.

During this inspection we identified a number of concerns and breaches of regulation. Each breach of regulation we identified corresponded to a breach of regulation which had been found during our previous inspection in December 2016. This means the service had failed to improve enough in each area we had identified and made requirements for them to act on. In addition we identified two further breaches of regulation during this inspection in March 2018.

Following our inspection in December 2016 the service had sought guidance and help from the Devon County Council Quality and Improvement team. Although they had taken the initiative to seek this support, the Devon quality and improvement team had recently chosen to stop working with 1-4 Windsor Drive due to their failure to improve, although the team were still currently working with the provider at the time of inspection. This meant the service had not only failed to make sufficient improvements to meet their legal requirements under the Care Quality Commission, but had also failed to make sufficient improvements to satisfy the County Council.

We found a clear programme of audits and checks in place, these had not identified our concerns. For example, although checks and audits were in place to review medicines and although the registered manager assured us improvements had been made to the medicine management systems following a recent medicines error, we found a number of inconsistencies with regards to medicine stocks.

Where changes had been made in response to our previous inspection, we found these had not been reviewed to identify whether they were having the required impact. For example, although the service had increased staffing hours, these increases had not been sufficient enough or organised well enough, to ensure people had their needs met. And although the service had stated in their action plans that they would be increasing people's access to the community and outside activities, we found this was not sufficient enough to meet people's social needs.

People's records were not always accurate and therefore people were at risk of not receiving the care they required. For instance, one person's care plan gave different information about the amount of thickener the person should have in their drinks. Some entries stated they should have one scoop per 100mls and others stated they should have two scoops per 300mls. The registered manager and staff were able to tell us which of these amounts was correct, but this could have posed a risk should an agency member of staff work with this person and rely on available documentation being accurate.

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

2014.

The leadership at 1-4 Windsor Drive consisted of a registered manager and two deputy managers. Staff gave us mixed views about the leadership of the service, with some telling us it was very supportive and open and others being very negative about it. Relatives told us they felt the management was approachable and would respond to any concerns they may have. We observed the management interacting with people and found these to be very positive. Relatives told us they felt comfortable sharing their views and one relative told us they had been asked to fill in a survey to share their feedback.

The registered manager was aware of their responsibility regarding duty of candour, that is, their honesty in reporting important events within the service, and their need to keep CQC up to date with important events within the service.

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 RA Regulations 2014 Person-centred care The provider failed to ensure people received care and treatment that was appropriate to meet their needs and reflected their preferences. This included opportunities to spend time outside of the service. Regulation 9 (1)(2)(3)(b)

The enforcement action we took:

Notice of Proposal to impose a condition on your registration for the regulated activity Accommodation for persons who require nursing or personal care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Failure to follow the five principles of the Mental Capacity Act 2005 had potentially led to two people having their rights infringed upon Regulation 11 (3)

The enforcement action we took:

Notice of Proposal to impose a condition on your registration for the regulated activity Accommodation for persons who require nursing or personal care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from risks associated with the management of medicines and risks relating to their conditions had not always been assessed and acted upon. Reg 12 (1)(2)(a)(b)(g)

The enforcement action we took:

Notice of Proposal to impose a condition on your registration for the regulated activity Accommodation for

persons who require nursing or personal care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had failed to assess, improve and monitor the quality and safety of the service provided. People's records were not always accurate. Reg 17 (1)(2)(a)(b)(c)

The enforcement action we took:

Notice of Proposal to impose a condition on your registration for the regulated activity Accommodation for persons who require nursing or personal care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing numbers were not sufficient to ensure people's needs were being met. Staff were not being supported with regular supervisions. Reg 18 (1)(2)(a)

The enforcement action we took:

Notice of Proposal to impose a condition on your registration for the regulated activity Accommodation for persons who require nursing or personal care