Allison O'Donnell Martin Limited

Windmill House

Inspection report

4-5 Windmill Close
Cockermouth
Cumbria
CA13 9BF

Tel: 01900822127

Date of inspection visit:
26 November 2015
27 November 2015

Date of publication:
24 February 2016

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

Summary of findings

Overall summary

This inspection took place on 26th and 27th November 2016 and was unannounced. This was the first inspection of the service since registration.

The home 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. This person was also the nominated individual for the company.

Windmill House provides personal care. At the time of our inspection they provided personal care and support to three people who were the tenants of Windmill House. The staff team did not provide any personal care services to any other people.

We found that the service did not ensure that people were kept safe from harm or abuse. This meant that the service was in breach of breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper conduct. This was because not all staff had received training and potential safeguarding incidents had not been referred to the local authority.

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

The service did not have enough staff hours to deliver care to people who used the service. This was a breach of Regulation 18 (1) Staffing because staffing levels were inadequate to meet assessed needs.

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

The organisation managed recruitment and disciplinary processes appropriately.

Medicines were being administered appropriately but we recommended that the registered manager completed audits of medicines in the service.
We also recommended that infection control audits were completed.

Staff induction, training and supervision did not meet the needs of the staff team. This meant that the service was in breach of breach of Regulation 18(2) because staff were not being suitably developed in their roles.

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

Staff were unaware of their responsibilities under the mental Capacity Act 20015. Where people lacked

capacity suitable procedures were not put in place to gain consent. The provider was in Breach of Regulation 11: Need for consent.

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

The staff provided people who used the service with suitable meals but the service did not use nutritional planning to ensure everyone's needs were being met. The provider was in breach of Regualtion14: Meeting nutritional and hydration needs.

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

We observed staff who were caring and considerate with people who used the service. We judged that a more person centred approach needed to be taken and we recommended that more emphasis be placed on supporting people to be as independent as possible.

All three people who used the service had care plans in place. Some aspects of care and support were not included in the care plans. Plans were not written in a person-centred way. This meant that the provider was in breach of regulation 9: Person-centred care.

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

Complaints were not always managed appropriately and this meant that the provider was in breach of Regulation 16: Receiving and acting on complaints.

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

The registered manager was not available and staff were unsure of who was in charge of the service in her absence. Quality monitoring systems were not operating effectively in the service. This meant that the provider was in breach of Regulation 17: Good governance.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.
For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from harm and abuse because safeguarding procedures were not being followed.

There were not enough staff to support the people who used the service.

The quality monitoring of medicines had not been completed.

Is the service effective?

Inadequate

The service was not always Effective.

Some staff had received no training.

Staff did not understand their responsibilities in relation to the Mental Capacity Act.

Nutritional planning was not in place.

Is the service caring?

Requires Improvement

The service was not always Caring.

We observed kind and considerate care from staff but had evidence that may have indicated that this did not always happen.

Care plans were not written in an easy read format and were not accessible to people in the service.

Independence needed to be promoted in the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care planning failed to meet some of the needs of the people who used the service.

Activities were limited and did not always reflect peoples wishes.

Complaints were not handled appropriately.

Is the service well-led?

Inadequate

The home was not well led.

Staff were unsure about who led the day to day care delivery in the absence of the registered manager.

Records were unavailable or incomplete.

The service had not monitored or evaluated quality in the service.

Windmill House

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 of the location took place on 26th and 27th November 2015 and was unannounced.

On Thursday 26th November 2015 the visit was conducted in the early evening by an inspection manager and an adult social care inspector. The visit the next day was conducted by the adult social care inspector. We were unable to visit the registered office of the provider at this inspection.

We met the three people who used the service and we spoke with three relatives prior to the inspection and after the visit. We met with five staff and spoke to other members of the team by telephone. We also spoke with the director of the company. The registered manager (who is also the nominated individual for the company) was unavailable during and after our inspection.

We looked at three care files, records of money held on behalf of people who used the service and the medicines the staff supported them with.
We looked at staff files in the location. We saw some records of training and some supervision notes.
We looked at a range of records kept in the location but did not access any documents that were not held at Windmill House. Some information was sent to us after the visits.

Inadequate

Is the service safe?

Our findings

Not everyone who used the service expressed themselves verbally. We judged that people looked relaxed in their environment. We did have some evidence to show that people did not always feel safe.

There had been a recent safeguarding issue which had not been reported to the Care Quality Commission. When we looked in daily notes we also found two other instances where an individual's safety or wellbeing was in question. These had not been referred to the Local authority or reported to CQC.

Staff had received basic training in safeguarding awareness but the registered manager and the team had failed to identify these occurrences as possible safeguarding. One person on the team had not received any training on safeguarding. The company could not provide us with a whistleblowing policy.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not protected from harm or abuse.

Rosters showed that there were four staff available to deliver care to three people in the service who were never left alone in their property. Staff contracts showed that not all staff worked on a full time basis. We judged that there was insufficient staffing to deliver the required levels of care and services. The director of the company said that she felt that much of the support needed was not covered by the care hours purchased. The company did not only go in to deliver care but had also assumed all of the social, financial and environmental support.

Shortly after our visit the company director felt that the issues around staffing were insurmountable and made a decision to wind up the company. This was partly because it was becoming difficult to cover all shifts with two members of staff.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked for evidence related to recruitment and saw some staff files which did not give us suitable evidence. Recently recruited staff told us that they had been recruited appropriately but we were unable to make a judgement on this because the records were incomplete.

The director of the company said that there were disciplinary processes in the service and we saw some evidence of the application of these processes. We also had evidence to show that the director of the company could access suitable support if necessary to conduct a disciplinary investigation.

We recommended that disciplinary processes be updated and that the registered manager receive some training in these matters.

We checked on medicines kept on behalf of the three people in the service. We saw that staff signed when

medication was given but we could find no audits of medication management. In one person's file we saw that despite advice being given by a psychiatrist staff had asked the GP to restart a major sedative. The service did not have a controlled drugs book. Staff had not received recent training on medicines administration.

We recommended that quality checks of medicines be completed routinely.

The home of the three people who used the service was clean and orderly with staff aware of the need for infection control measures. We could not find any documents related to infection control.

We recommended that the policy on infection control be updated.

Inadequate

Is the service effective?

Our findings

Three of the four staff had received training on what the registered person considered to be mandatory training. This included moving and handling, safeguarding, health and safety and end of life care. Staff had not received training on caring for people living with dementia. There had been no recent training on supporting people with learning disabilities and no training on person centred thinking or person centred planning. One person on the team who had been in post for approximately eight months had not received any training but was, at times, working alone.

We asked staff about supervision and appraisal. Staff gave us varied responses with some team members saying that they had never had supervision, some saying there had been none since registration. The company director told us she had been advised by a social worker to complete supervision with staff. The company director did not have a care background. There were no supervision notes or records of appraisal available on the two days of our visit.

This was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff training did not give all staff the skills and knowledge required. Staff were not being supported to develop in their roles.

Staff had not received training on the Mental Capacity Act 2005. Staff we spoke with did not understand the importance of "best interest" reviews and no one in the organisation had considered whether they needed to look at the restrictions placed on people in their care. People were being deprived of their liberty but no one had considered the implications of this in relation to the Mental Capacity Act 2005.

We looked at care plans and at daily notes. We could not find evidence to show how consent was sought in the service. No one on the staff team could give us any definitive answers about whether any person had the power of attorney for the individuals. Case files did not show when people were under the care of the office of the public guardian.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because there were no formal arrangements in place for gaining consent where people lacked capacity.

We learned from staff that they always sat with people at meal times and we observed a sociable dinner time on the first day of our visit. People were given a well prepared meal that had been cooked 'from scratch'. Staff said that they cooked everything from scratch but we saw that money was also spent on frozen ready meals. One person had problems with swallowing and another had some issues with maintaining a healthy weight. There were no nutritional plans on file and there had been no visits from dieticians or experts in swallowing. Staff weighed people but were unsure if the scales had been calibrated. They were not sure if the weights were correct. Staff did not record the body mass index.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014 because nutritional planning was not in place.

People in the service were supported to access health care. They were helped to visit the GP and to see other health care professionals.

People lived in two houses and they were tenants in these properties. Staff supported them to live safely in these properties. There was suitable office space in these properties.

Requires Improvement

Is the service caring?

Our findings

We met all three people who were in receipt of services. We observed people in the service and we judged that on the days we visited the people who used the service were relaxed and confident in the care they received from the team.

We judged that the interactions we saw on the day were caring, respectful and kind. We did have some information that may have meant that not all interactions were kind, respectful or dignified. These matters were referred as a potential safeguarding matter.

On the days of our visits staff supported people well and took time to explain any interactions. Care files did not use 'easy read' formats so some information was not accessible to people with learning disability

We looked at the care plans for people and we judged that there needed to be more focus on encouraging people to be as independent as possible. We did see that staff encouraged people, where possible, to do things for themselves.

We recommended that the team revisited some of the core values of dignity, privacy and respect and that a person centred approaches to care delivery be adopted.

Requires Improvement

Is the service responsive?

Our findings

We looked at all three care files and we saw that although these did give some details of people's needs and preferences these were not written in a person centred way. Assessments of need had been completed but some assessed needs and preferences were not recorded. Every person had a care plan but no one had a person centred plan with personal goals. Where people had difficulty managing their emotions or behaviour the plans lacked robust guidance. There was no evidence that the staff team had taken advice from professionals who could assist with these needs.

All three people went to a day centre for at least four days per week. One person told us they didn't want to go to the centre quite so often. Staff took people out where possible and tried to engage them in activities at home. A relative felt that the people who lived in the property were not given enough stimulation and we judged that activities were somewhat limited. The staff team said they did not have enough hours to do as many activities as they wanted. We checked the details of the purchased hours and these did preclude more outings and activities. The director of the company said that she and some of the staff did take people out in their own time as they were aware of the restrictions on activities.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because care planning and activity planning were not undertaken in a person-centred way.

We had evidence to show that a complaint had been received but had not been investigated appropriately. We could not find any details which would point to a complaint investigation being undertaken. The complainant was unhappy with what they saw as a lack of response.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because a complaint had not been handled appropriately.

Inadequate

Is the service well-led?

Our findings

At the time of our visit the registered manager was not at work. We asked staff on both days who was in charge during her absence. Staff said they did not know or that the company director was in charge. We needed to talk to someone in charge on the evening of the first day and the director did not answer her phone until late in the evening. We asked staff if there was an on-call system but they said there wasn't. They said that they would call Care Line if there was a problem

We saw there was a Care Line call system in the office at the location. This was used by staff as we were told that the people who used services were not capable of using the call line. People in the service were paying for this service and also paying for staff time. There was no working emergency plan and no one person in charge. The organisation had one senior carer but she had not been left in charge in the absence of the manager.

We discovered that there were a number of occurrences that should have been reported to CQC but these had not been sent to us.
The failure to notify us of matters of concern as outlined in the registration regulations is a breach of the provider's condition of registration and this matter is being dealt with outside of the inspection process.

We were told by the director of the company that there was a quality monitoring system in place. We saw that there were audits for the environment. This service was not a registered care home but the audits showed that staff looked after all of the environmental health and safety needs of the building. These checks were done routinely and problems reported to the director of the company. Some environmental maintenance had been dealt with by the organisation despite the service not being a registered care home.

We did not see routine checks on medicines or on care planning. The accounts for household bills and for individuals were detailed and up to date with all receipts in place. The records related to care delivery, staff development and competence were not available or had not been routinely completed.

We did find some evidence of audits being done but there was no evidence to show that the registered manager had looked at the service in its entirety based on audits and seeking the views of service users and their advocates. There had been no quality report prepared for the service since registration.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the monitoring of quality and the need for improvement were not being suitably managed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care delivery failed to identify individual person centred needs and aspirations.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There were no formal arrangements in place for seeking consent from people who lacked capacity.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Staff had not reported potential safeguarding matters. Some staff had not received training.

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Nutritional planning was not in place.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints

A complaint had been received but had not been dealt with in a timely or appropriate manner.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in the service for monitoring quality were not being managed appropriately. Staff were unsure of who was in charge in the absence of the registered manager.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels did not meet the needs of the people who used the service and not all staff had received suitable training to carry out their role.