Parkcare Homes (No.2) Limited

Windsor House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on the 23 May 2017 and was unannounced.

Windsor House is registered to provide accommodation and personal care for up to 14 people. People living at the service had a range of learning disabilities and required support with behaviours which challenged.

Downstairs there were two lounges, a kitchen and dining room. There were 14 bedrooms and some bathrooms spread across the remaining two floors. At the time of the inspection there were 11 people living at the service.

There was no registered manager working at the service. 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 and associated Regulations about how the service is run. We were supported during the inspection by the quality lead person for the organisation, who had recently started overseeing the service and two service support managers. These were registered managers from other services run by the provider, who were providing support as needed.

We last inspected the service in June 2016. We found significant shortfalls in the service. We found that there were not enough staff on duty to meet people's needs and enable them to access activities in the community. Some people had Deprivation of Liberty Safeguards (DoLS) in place because their liberty was restricted. The conditions of the DoLS had not always been met. Full assessments had not always been carried out before people moved to the service. Risks relating to one person's health and wellbeing had not been assessed to protect them from harm. Notifications of significant events within the service had not been sent to the Care Quality Commission (CQC), in line with current guidance.

We asked the provider to provide an action plan to explain how they were going to make improvements to the service. At this inspection we found that no improvements had been made to the service. Four breaches of regulations identified at the last inspection continued and there were three additional breaches of regulations.

There had not been a registered manager in post since the beginning of 2017. There had been no structured leadership and oversight of the service since then. Shortfalls found at this inspection had not been identified; however, some action was taken during the inspection. There was an action plan in place to address the breaches of regulations found at the last inspection. There were 25 actions but only eight had been completed. Audits and checks had not been completed since March 2017. Quality assurance surveys had not been sent to staff, people, relatives and other stakeholders, such as GP's, since 2015.

Full assessments had not been carried out before people moved into the service. Risks relating to one person's mobility had not been assessed and there was no guidance for staff about how to safely support

the person with their mobility. During the inspection it was identified by inspectors that staff had been supporting the person in an unsafe way since they moved to the service in November 2016. The service support managers reported this as a safeguarding issue and contacted the local safeguarding team immediately.

Some accidents and incidents had been recorded and these were analysed to identify patterns or trends. This analysis was used to update people's risk assessments or report incidents to other authorities. However, one incident had not been identified, recorded and analysed, the incident highlighted poor practice by staff and placed people at risk.

People said that they felt safe; however, there was not enough staff to meet people's needs. People were limited with the activities they could do, both in the service and the community. Some people had a DoLS authorisation in place, with a condition that they go out into the community weekly. This condition had not been met because there had not been enough staff. Recruitment for more staff had been started but there was no date for when additional staff would be in post.

Some people had recently had DoLS applications authorised by the local authority. The service is required by law to inform CQC about the outcome of DoLs applications, this had not done in line with current legislation. Some people's DoLS had expired and applications had not been re-submitted. There was a risk that people's liberty was restricted without authorisation.
Staff understood the principles of the Mental Capacity Act 2005 (MCA), people were given choices and best interests meetings had been held regarding people's care and support decisions.

There was a complaints procedure displayed in the service in a format that people could understand. However, complaints received by the service had not been responded to and investigated in line with the provider's procedure.

Some staff had received supervision to support them to carry out their roles. Staff had received training appropriate to their roles; however, this training had expired including moving and handling and how to safely administer people's emergency medicine. Refresher training had recently been booked.

People were involved in planning their meals. A visual menu was in place but not used as the pictures were missing. Some people had Speech and Language Therapy (SaLT) guidelines in place. Staff followed these so people could eat and drink safely. Prompt referrals had been made to healthcare professionals when required.

There was a safeguarding policy in place and staff knew how to recognise and respond to different types of abuse. Staff knew how to recognise different types of abuse but action was not always taken when staff reported concerns to management. Medicines were stored appropriately. People received their medicine when they needed it and were encouraged to be as independent as possible when taking their medicines.

Staff were kind and caring and knew people well. They treated people with respect and dignity. Some people required additional support with their communication and their needs and preferences were understood by staff. The quality lead for the organisation who was acting as the manager had an open door policy, people were happy to stop at the office and chat to whoever was in there at the time.

Checks had been made on the environment to ensure that people were safe. Fire drills had been held so that staff and people know what to do in an emergency. Each person had a personal emergency evacuation plan (PEEP). A PEEP sets out specific physical and communication requirements that each person has so they

can be evacuated safely.

We found breaches of seven regulations. You can see what action we told the provider to take at the back of the full report.

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 consistently safe.

There was not sufficient staff on duty to meet people's needs. Staff were recruited safely.

Risks relating to one person's health and wellbeing had not been assessed to protect them from harm. There was guidance in place to manage risks, relating to behaviour that challenged, for other people.

Staff knew how to recognise different types of abuse but action was not always taken when staff reported concerns to management. People's money was managed safely.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Some people had Deprivation of Liberty Safeguards (DoLS) authorisations in place. Conditions on these DoLS had not always been met. Staff had an understanding of the Mental Capacity Act and best interests meetings had been held when people lacked capacity to consent to care and support.

Staff had received induction training but this had not been updated to ensure staff were working to best practice standards.

People were supported to eat a healthy diet.

There was guidance in place to support people with their healthcare needs. People were supported to access healthcare professionals as needed.

Is the service caring?

Requires Improvement

The service was caring.

People were treated with dignity and respect and were encouraged to be as independent as possible. However, low staff

levels impacted on the amount of time the staff could spend with people.

Some people required support with their communication and their needs and preferences were understood by staff. However, there were no suitable tools, including pictures for people to know what was happening in the service.

People were relaxed and happy in the company of staff.

People decorated their rooms to their personal preferences.

Is the service responsive?

Inadequate

The service was not consistently responsive.

People's needs were not assessed before they moved into the service. Staff did not have clear guidance on how to support one person

People did not always have the opportunity to do the activities they wanted to do outside of the service, due to a lack of staff.

Complaints had not been investigated and responded to in line with the provider's policy.

People met regularly with their keyworker and could raise concerns if needed.

Is the service well-led?

Inadequate

The service was not well led.

There were continued breaches of regulations.

The Care Quality Commission (CQC) were not always informed of events as required by law.

Shortfalls in the service had not been identified.

There was no registered manager in post, there was no consistent oversight of the service.

Quality assurance surveys had not been sent since 2015 to staff, relatives and stakeholders.

People had monthly meetings to discuss their care needs.

Windsor 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 took place on 23 May 2017 and was unannounced. It was carried out by two inspectors.

The provider had not completed a Provider Information Return (PIR), as the inspection had taken place earlier than expected. The PIR asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. Before the inspection we reviewed all the information we held about the service, the previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with the quality lead for the organisation, two service support managers and three care staff. We looked at four care plans and associated risk assessments and guidance. We reviewed checks and audits, supervision, training and recruitment records. We spoke with people living at the service. We observed how people were supported and the activities they were engaged in.

Some people were unable to tell us about their experience of care at the service. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We last inspected Windsor House in June 2016.There were four breaches of regulations at that time.

Inadequate

Is the service safe?

Our findings

People appeared to be happy and safe in their environment. People were relaxed in the presence of staff. Staff knew people well and had built up relationships with the people they supported.

At the last inspection in June 2016, we found there was not enough staff to meet people's needs, especially their social needs. At this inspection staffing levels had not improved. There were 11 people living at the service. On most days records showed there were four staff on duty. The staff were expected to cook as well as support people. At the time of the inspection, the cleaner was on maternity leave, and so the staff were cleaning the service. Some people required the support of two staff for their personal care. One person needed one to one staff support for nine hours a day as they displayed behaviour that may challenge. There was no system in place to ensure the person received the one to one support they had been assessed for. There was a risk that staff would not be able to provide support the person needed to keep them and others safe.

Staff told us that it was difficult to manage all the elements of their role on a daily basis, one staff member said "If one of us is cooking and the others are helping people with their care, we can't do the things with people we want to do." "At least with five staff, there is usually the opportunity to take people out." People who had complex needs and required support with their mobility and communication had not gone out for over a month, staff told us this was because there had not been enough staff. We observed people go out during the inspection, they were able to mobilise independently and required little or no support from staff.

During the inspection there were five staff on duty, two were temporary staff from an agency. Staff told us that there would usually only be four staff on duty but there had been a mistake and one agency staff member had not been cancelled. The quality lead for the organisation told us that they had used a dependency tool to reassess the staffing levels and received authorisation to increase staffing levels during the day to five and that recruitment had started. We were shown evidence that three staff had been recruited for bank (occasional) shifts but had not yet started work at the service. During the inspection, the service support manager confirmed that they would now be recruiting a cook for Monday to Friday.

After the inspection the quality lead confirmed that there were now five staff on duty during the day. They also confirmed that people had been taken out each day since the inspection.

The provider had failed to ensure there were sufficient numbers of staff deployed to meet people's assessed needs. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, one person had moved into the service and staff did not have detailed guidance on how to support the person safely. At this inspection there had been no improvement.

One person moved into the service in November 2016 from another service within the provider's group. The person had moved as their needs had changed and they were no longer able to mobilise. The care plan in

place was from the previous service. There were no risk assessments in place to give staff guidance on how to support the person with their mobility needs. There had been an incident where the person had nearly slipped off a shower chair and staff had moved the person without using equipment. Staff told us this was normal and that they always moved the person by using a 'drag lift' as the person had not been assessed for equipment to assist with moving and handling. This practice of using a 'drag lift' placed both the person and the staff at risk of injury.

The service support managers told us that the person had been referred to the occupational therapist but they had not assessed the person because they did not have a learning disability. The person had been referred again but at the time of the inspection the person had not been assessed. The service support managers told us there was no one within the company who could assess people's mobility support needs.

During the inspection the support manager raised a safeguarding alert with the local authority about the use of unsafe moving and handling techniques.

The provider had failed to access and mitigate the risks to the health and safety of people of receiving care. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were risk assessments in place for the other people at the service. We observed staff support people positively with their specific behaviours. There was clear information to show staff what may trigger behaviour and staff were aware of the strategies to minimise any future occurrence. Staff responded to one person's behaviour, using the strategies outlined in their care plan.

Some accidents and incidents had been recorded and these were analysed to identify patterns or trends. This analysis was used to update people's risk assessments or report incidents to other authorities. However, one incident had not been identified, recorded and analysed. The incident of the person nearly slipping off a shower chair, highlighted poor moving and handling practice by staff and placed the person and staff at risk. The management team had not been aware of the incident and staff poor practice until highlighted during the inspection.

Staff knew how to recognise and report different types of abuse but their concerns had not always been acted on. Staff told us they would report any concerns to their manager. One staff member told us they had recognised that poor moving and handling practices were a safeguarding issue. They had raised this at their recent supervision but action had not been taken by the manager in post, who no longer worked at the service. There were two other incidents that had not been raised as safeguarding issues by the previous manager. The provider had failed to check that the right action had been taken in response to safeguarding concerns raised by staff.

The quality lead and service support managers were aware of their responsibilities to report safeguarding concerns to the local authority. Safeguarding referrals were made to the local authority during the inspection, when these issues were identified. People's money was managed safely and audited regularly.

The provider had failed to take appropriate action when safeguarding concerns were raised. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Health and safety checks on equipment and the environment had been completed. A fire risk assessment had been completed in February 2015, remedial work had been identified. This work had not been completed, this had not been identified until May 2017, when action to start the work had been taken.

Environmental checks had identified remedial work that needed to be completed. Documentation to confirm the work had been completed was sent to us following the inspection.

Fire drills had been held regularly involving both staff and people. Each person had a personal emergency evacuation plan (PEEP). A PEEP sets out the specific physical and communication requirements that each person has to ensure that they could be evacuated from the service in the event of an emergency.

Staff were recruited safely. Recruitment checks were completed to make sure staff were honest, reliable and trustworthy to work with people. These included a full employment history. At the last inspection we recommended that the provider ensured all references were satisfactory before people started work. References were now checked to ensure that they were satisfactory and from previous employers. Disclosure and Barring Service (DBS) criminal records checks were completed before staff began working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services.

People received their medicines safely and in the way they preferred. There were appropriate arrangements in place for obtaining, recording, administering and disposing of medicines. Medicines were stored at the correct temperature to ensure they were effective. People were supported to be as independent as possible when taking their medicines. People's medicines were stored securely in their rooms. Medication administration records (MAR) charts were fully completed, showing people received their medicines when they needed it. Some people had medicines on an as and when basis. There was guidance for staff on when these should be administered. Creams were kept securely and applied by staff. Staff did not record the application of the creams separately from medicines. This was an area for improvement.

Requires Improvement

Is the service effective?

Our findings

People living at the service had a wide range of health and support needs. Staff knew people well and how to support them.

At the last inspection, the provider had failed to ensure that conditions on people's Deprivation of Liberty Safeguard authorisations were met. At this inspection we found that improvements had not been made.

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 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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Some people's liberty or freedom was restricted. Some people lacked capacity to agree to the restrictions so DoLS authorisations had been applied for to ensure any restrictions were lawful. Sometimes, DoLS are granted with conditions to ensure people's rights are upheld. The conditions on people's DoLS were not always met. One person's DoLS had the condition that they are taken out into the community and that the authorising authority (the person's funding council) be informed if this did not happen. The person's daily records showed that they had not been supported to go out since March 2017. The quality lead told us that the person had not wanted to go out, however, they did not know how the person had communicated this and this had not been recorded. Staff told us that they had been unable to take the person out as there were not enough staff. The authorising authority had not been informed that the person had not been out into the community or that the condition of their DoLS had not been complied with.

When DoLS are authorised, it is for a limited period of time so an application for the authorisation to continue needs to be re-submitted to the local authority. Some people's DoLS had expired and applications had not been re-submitted. There was a risk that people's liberty was being restricted without authorisation making it unlawful.

The provider had failed to ensure that conditions on people's DoLS were met and the authorising authority was informed. People were restricted or constantly supervised unlawfully. This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were mental capacity assessments in place for people who were unable to make decisions for themselves. Best interests meetings had been held to decide if people needed support with personal care or medicines. The mental capacity assessments had not been reviewed since 2015 so people's level of capacity

may have changed. Staff were aware of their responsibilities under the Act and we observed staff giving people choice when they were able to make decisions. Staff understood the support required by people with complex needs, staff were able to tell us how they supported people. Staff were aware of people preferences and this was reflected in the support the staff gave.

Staff had received some training appropriate to their role. The training had not been updated as required by the provider's policy to ensure staff were competent and working to recognised best practice standards. Essential training had not been updated such as moving and handling. During the inspection, we observed people being moved safely, as documented in their care plan. In one person's daily notes, staff had recorded that the person had been moved by using the 'drag lift' and staff confirmed this was how the person had been moved. The person was not at the service during the inspection. Staff had received training in Makaton sign language and used this to communicate with people when appropriate.

The shortfall in training had been identified and training had recently been organised and staff had already started to attend sessions. Staff told us that they had been observed to check their competence in administering medicines and had completed additional training. Staff spoke about people's needs with knowledge and understanding.

Staff had received one to one supervisions. Staff had not received a recent appraisal. Staff told us that they had not felt supported as the management structure of the service changed and they were unsure what was going to happen next.

New staff worked through induction training during a six month probation period, which included working alongside established staff. Staff completed the Care Certificate as part of their induction, which is an identified set of standards that social care workers work through based on their competency. Staff knew people well, staff were able to describe the support people needed with their complex needs. We observed staff supporting people in the way they had described, that had been detailed in their care plan.

People were supported to eat a healthy balanced diet. People were involved in planning the weekly menu. People were given a choice of meals; however, some people needed support to make choices and there were no pictures to help people decide what they wanted.

We observed the lunchtime meal. People were seated in the dining room, all the staff were involved in serving the meal but there was little interaction between staff and people. One person shouted "It's my birthday today." There was no response from staff, the person then asked people to guess how old they were. The agency member of staff eventually answered the person. People's meals were served at intervals, so people were eating at different times. People appeared to be accepting of having their meals served at different times. People, who needed support with their meal, were assisted by staff. One person required a specific bowl and spoon to be able to eat independently, staff ensured they had the correct equipment as recorded in their care plan.

Some people had eating and drinking guidelines in place from a Speech and Language Therapist (SaLT). Staff followed these guidelines and food and drink were served at the correct consistency. Staff told us how they ensured they thickened a person's drink and how they assisted them to drink safely, as recorded in the person's care plan. Staff monitored people's weight to identify when people lost weight, and referred people to the dietician when needed.

People's health needs were recorded so staff knew how to support people. One person was living with epilepsy. Their care plan described what type of seizures they may have and how to support them safely

during a seizure. There were guidelines for when the emergency services should be called and any medicines that might need to be administered.

There were documents in place for people to take to hospital with them. The information included people's health needs, how to communicate with the person and their medicines. People had health action plans in place detailing their health needs and the support they had received from healthcare professionals.

When people attended health care appointments, they were supported by staff who knew them well, and who would be able to communicate their needs to healthcare professionals. People had access to professionals such as opticians, dentists and chiropodists, appointments and outcomes had been recorded.

Requires Improvement

Is the service caring?

Our findings

People were happy and relaxed in the company of staff. Staff were considerate and treated people with dignity and respect. One person told us, "It's my birthday and I am having a party. I have brought all the food."

Staff knew people well and knew how to communicate with them effectively. Some people were not able to communicate verbally and had additional communication needs. There was detailed guidance in people's care plans about how to communicate with them. Throughout the inspection staff were able to understand people's needs and wishes and the way in which they preferred to be supported. Staff communicated using Makaton sign language when appropriate. There were no photos or pictures to tell people which staff were on duty, what activities were taking place or what was to eat that day. People were reliant on staff telling them what was happening during their day.

Staff responded to people in a kind way, one person made a noise and banged the object they had in their hand. Staff went to them and sat with them giving them another object and offered them a drink, the person settled and appeared to enjoy the drink.

People's daily routines were recorded in their care plans to ensure they were supported in their preferred way. Staff knew people's preferences and had included details about how people liked to have a bath or shower, and how they liked to be dried or clean their teeth. There were details about how people liked to spend their time and what was important to them. One person worried that people would take their collection of wool, staff knew how to reassure the person and put their mind at rest.

Staff were given guidance on how to support people with behaviours that may challenge. Staff recognised when one person was becoming agitated and that their behaviour may become challenging. Staff approached the person in a calm and respectful way, engaged them in conversation and suggested that they do something else that the person enjoyed. The person became calm and responded in a fond way to the member of staff, laughing with them and following them to another room.

Staff treated people with respect. Staff asked people for their permission before they went into their rooms, gave people choices about what they wanted to do and respected their decisions. One person was going out to the shop, they had a jumper on and it was a warm day, staff suggested they may want to wear a t-shirt. The person said it was their favourite jumper and they wanted to wear it. When they came back they changed into a t-shirt, laughing that the staff were right.

People were able to personalise their own bedrooms. One person wanted to show us their room, they had chosen the furniture and colours to match, and there were photos of their family on the wall. Some people, who were able, were encouraged to look after their rooms, to keep them tidy and help to clean them.

Some people, who were able to go out independently, were encouraged to manage their own spending money. For other people, the lack of staff meant that could not go out so often. People were given their

money each week and were able to spend this it as they wanted, such as wool or rings from the charity shop. People understood that the money was for a week, one person showed us that they had money left at the end of the week. There were goals and objectives in peoples care plans, staff supported people, when they could to work towards these goals to improve their lives. People were encouraged to meet with their keyworker each month to give their views on their care and make suggestions.

Family and friends were able to visit whenever they wanted. Staff supported people to stay in touch by card or in person. On the day of the inspection, there was a birthday party and everyone was encouraged to join in. The person was given presents. A visiting reflexologist, had come in with a cake that the person could decorate. There was lots of laughter while the cake was decorated and eaten.

People were supported in a discreet way, staff approached people calmly and spoke to them in a quiet voice. Staff supported people to go into their own bedroom when they were supported with personal care.

Staff completed handover sheets about what had happened to people during their shift. Staff discussed any changes in people's support with each other at the changeover of shift.

People's care plans and associated risk assessments were stored securely and locked away so that information was kept confidentially.

Inadequate

Is the service responsive?

Our findings

Staff did their best to support people in the way they wanted, however, staff were not always responsive to their needs. People's needs were not always assessed before they moved into the service and some people were not able to access activities outside the service.

One person had moved to the service from another of the provider's services. No assessment of the person's needs had been completed before they moved into the service to make sure that staff were able to meet the person's needs. The person had moved into the service in November 2016. The care plan available for staff to refer to was from the previous service and did not have up to date information about the person's support needs such as their mobility needs. The service support manager showed us a new care plan that had been started on the computer, but this did not give detailed guidance for staff to be able to support the person safely. Staff had recognised that the person's mobility needs had changed and referred them for an occupational assessment of their mobility needs. However, staff had not been given guidance on how to meet the person's needs safely while waiting for the assessment. Staff told us that the person had been moved by using the 'drag lift' which can cause harm to the person and staff; they had not used equipment, as is best practice. The person was not at the service during the inspection.

Some people required additional support with their communication needs, staff understood people's communication needs and we observed staff support people as recorded in their care plan.

Some people required support to take part in activities within the service and to go out. Staff told us that there had not been enough staff to take people out as often as they would like. There were no activity plans in place for people so no activities planned in advance each day. Activities were ad hoc and depended on staff having the time to arrange and lead them. As staff levels were often too low, activities were limited. During the inspection two people, who required support, were in the lounge, they had tactile objects to play with and the television on but had no stimulation from staff, who were not present in the lounge as they were busy with their other roles. Some people had not been taken out of the service since March 2017. Daily diaries showed that some people had not taken part in meaningful activities for some time.

People who were able to leave the service independently, were able to go out and spend their time how they wanted. One person showed us their rings and told us, "I like to go to the charity shops and buy my rings." Other people spent time in their rooms and enjoyed watching films or making things with the wool they had collected. One person told us how they had planted pots in the garden and was looking forward to spending time in the garden. People were supported to hold a birthday party on the afternoon of the inspection. These opportunities for activities were not available to everyone due to a lack of staff.

After the inspection, the quality lead told us that staffing levels had been increased and people had been out each day. We will follow this up at the next inspection.

The provider had failed to carry out an assessment of needs and support the preferences and choices of service users. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

There was a written complaints procedure that was displayed at the service. This was also produced in a format that was more meaningful to people. There had been three complaints recorded since the last inspection. Two had not been responded to in line with the provider's policy. A complaint that was made in December 2016 had not been responded to until May 2017, the quality lead agreed that the response had not resolved the issue. The second complaint had been raised in December 2016, it had concerned the attitude of a member of staff, and this had not been investigated. There was another incident involving the same member of staff in March 2017, which had led to disciplinary action.

The provider had failed to ensure complaints received had been investigated and appropriate action taken in response. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were care plans in place for the other people living at the service. Each care plan gave details about how people liked to be supported. For example, one person did not like people standing too close to them, there was guidance about how to wash and dress them without standing too close to them so the person did not become distressed.

There were positive behaviour support plans in place for each person to help staff understand and respond appropriately to people's behaviour. These stated any potential triggers for behaviours, the level of behaviour and how staff should respond to each level of behaviour. One person displayed behaviours that may challenge; there was guidance for staff to be able to support them. We observed staff support the person, using techniques described in the care plan, these had calmed the person down and encouraged them to change their attention to something else.

People had the opportunity to meet with staff each month, to talk about their care. People who needed support to communicate were shown pictures so that they could indicate how they felt. Care plans were reviewed and changes in people's needs were recorded.

Inadequate

Is the service well-led?

Our findings

The management of the service had been unstable for some time. The previous registered manager had left at the beginning of this year. There was no deputy manager in post. A new manager had been appointed but had left after a month in post. It is a condition of the provider's registration that the service has a registered manager in post.

On the day of the inspection, the provider's quality lead person was overseeing the service. They were supported by two service support managers who were registered managers from other services run by the provider. The quality lead did not have access to all of the computer systems that were used to support the service. The quality lead told us that the provider was in the process of recruiting a new manager and deputy manager for the service.

The breach of regulations found at the last inspection had not been met. There were further breaches of regulations found at this inspection.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC), of important events that happen in the service. CQC then check that appropriate action has been taken. At the last inspection, the provider had not notified CQC of events that had stopped the service running safely and properly. During this inspection, we found that we had not been notified about the outcome of Deprivation of Liberty Safeguards (DoLS) applications as required by law.

The provider had failed to notify CQC in a timely manner of important events that happen in the service, namely the outcome of Deprivation of Liberty Safeguards applications. This was a continued breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

Staff told us that the changes in management meant that the service was not improving, and left them feeling demoralised. They said that they did not have enough staff to give the support and opportunities to people that they wanted. They told us, "We treat people well, but it is not easy when we don't have enough staff."

At the last inspection, the registered manager, had also identified that there was a shortage of staff. They had informed us after the inspection that an additional member staff was on duty. However, at this inspection there were fewer staff on duty than at the last inspection. The quality lead had identified that more staff were needed to support people and recruitment had started. Since the inspection the quality lead informed us that there was now an additional member of staff on duty.

Audits had been carried out on a variety of areas such as the environment and records; however, these had not been completed since March 2017. There was an action plan in place to address the shortfalls identified at the last inspection in June 2016, the progress had been rated and there were areas where no progress had been made.

The service support manager told us that there were regional audits in place and unannounced bench marking inspections; however, these had been ineffective as they had not identified the shortfalls in the service. For example, not all care plans had up to date information and risk assessments, conditions on people's DoLS authorisations were not being met. Complaints had not been responded to and investigated in line with the provider's procedures. Accidents and incidents had been recorded and analysed at the providers head office and information sent to the quality lead, however, not all incidents had been identified and recorded. There was a risk that not all risks had been identified.

Staff had received supervision but concerns raised had not been acted on. Staff had did not feel supported, they told us, "We were expected to move (the person) but were not told how to do this. The way we were moving (the person) put us and them at risk." Although staff had raised concerns with previous managers they had not been acted on so the unsafe practice continued.

The views of people and their relatives had not been gathered and acted on. Quality assurance surveys had not been sent to people, staff, relatives and other stakeholders such as GP's since 2015. Staff meetings had not been held so staff had not been given the opportunity to make suggestions about the service.

The provider had not ensured that they were compliant with breaches of the regulations identified at the last inspection. They had not fully adhered to and completed their action plan.

The quality assurance audits were not effective to ensure that all shortfalls in the service were identified and acted on. The systems to identify and assess risks to the health and safety of people were not detailed to show what measures should be taken to mitigate risks. They had not maintained accurate records. Stakeholder views had not been obtained and used to improve the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The staff team were committed to improving the lives of people who lived at Windsor House although this was difficult with a lack of staff. They treated people with respect and dignity. They were passionate about providing personalised care, upholding people's rights and choices and improving people's lives despite the lack of staff, support and the management changes.

During the inspection, people felt comfortable coming into the office. People knew the quality lead and were happy and relaxed to speak to them about what was happening that day. The quality lead spent time with people, in the dining room, chatting with them and helped with the birthday party. Staff knew they could speak to the quality lead but with the changes in the management of the service they were not confident that action would be taken.

People were able to express their views on the service at 'Your Voice' meetings but these meetings had not been held since March 2017. Suggestions made at these meetings about what people wanted to do or eat had been acted on.

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 will check that this action is taken by the provider.

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 CQC in a timely manner of important events that happen in the service, namely the outcome of Deprivation of Liberty Safeguards applications.

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 carry out an assessment of needs and support the preferences and choices of service users.

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 access and mitigate the risks to the health and safety of people of receiving care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to take appropriate action when safeguarding concerns were raised. The provider had failed to ensure that conditions on people's DoLS were met and the authorising authority was informed. People were restricted or constantly supervised

unlawfully.

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 ensure complaints received had been investigated and appropriate action taken in response.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The quality assurance audits were not effective to ensure that all shortfalls in the service were identified and acted on. The systems to identify and assess risks to the health and safety of people were not detailed to show what measures should be taken to mitigate risks. They had not maintained accurate records.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of staff deployed to meet people's assessed needs.