Windsar Care Limited

Windsor Care Centre

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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Windsor Care Centre can accommodate up to 72 people across two floors, each of which has separate adapted facilities. The service provides care to older adults. This also includes people who require respite care and people who are waiting discharge from hospital and need help to move from hospital back home or to another setting speedily, effectively, and safely. At the time of our inspection, there were 67 people living at the service.

People's experience of using this service and what we found
Even though people and relatives felt the service was safe, we found people were placed at risk of avoidable and significant risk of harm.

We found unsafe practices in several areas relating to safeguarding adults at risk of abuse, identifying, assessing and managing risks, staffing levels, medicines management, safety of the premises and infection control. We have made a recommendation about recruitment.

The service did not always do everything reasonably practicable to make sure people who used the service received person-centred care. Assessments did not always consider current legislation. People and relatives said staff were well skilled to provide care and support. We found there was a lack of specialist training on how to manage people living with dementia, delirium and mental health issues. People's nutritional and hydrations needs were captured but some staff did not always offer people a choice of meals and we observed staff rushing people and taking away their food when they had not finished. We have made a recommendation about this.

Improvements were required to ensure effective working with relevant health care practitioners, to ensure people, especially those with poor mobility have good health outcomes.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; The registered manager did not work in accordance with the Mental Capacity Act 2005 and its Codes of Practice. We have made a recommendation about this.

Quality assurance systems used to assess, monitor, and improve service delivery were inadequate. There was a lack of scrutiny and oversight at board level. This would ensure established quality assurance systems remained effective and the registered manager met regulatory requirements. Quality assurance audits failed to pick up on the concerns found during this inspection. There was no evidence to show lessons had been learnt when things went wrong. We have made a recommendation about the Duty of Candour.

The registered manager did take prompt actions to address concerns that required immediate action. However, a view of their training records showed, the level of role specific training undertaken for them to

work within the regulatory requirements, and to assess and support staff with delegated responsibilities, was insufficient.

The culture of the service was not always open and inclusive, and people felt communication from the registered manager was poor and some staff felt they were not listened to. The registered manager sought feedback from relatives' and staff but not all feedback was responded to and there were missed opportunities to make improvements to ensure peoples' welfare and safety.

Some people, relatives and staff gave positive feedback about care, support and management of the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was good (published 15 June 2018).

Why we inspected
The inspection was prompted in part due to concerns raised by a local authority and concerning information received relating to the management of people's care, medicine management, quality of care and management of the service. A decision was made for us to inspect and examine those risks. So, we widened the scope of the inspection to become a focused inspection which included the key questions of safe, effective and well-led. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

After our inspection the registered manager sent supporting evidence to show risks to people from faulty wheelchairs were now mitigated.

You can see what action we have asked the provider to take at the end of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well- led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Windsor Care Centre on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

You can see what action we have asked the provider to take at the end of this full report.

We have identified breaches in relation to quality assurance; risk management; building and premises, safeguarding management; consent; person-centred care; management of medicines and staff training

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led Details are in our responsive findings below.	**Inadequate**

Windsor Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors, a specialist advisor who was an occupational therapist and an Experts of Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Windsor Care Centre is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 17 August 2022 and ended on 22 August 2022. We visited the location's office on 17 August 2022 and conducted telephone interviews with one service user and eight family members on 19 August 2022 and three staff members on 22 August 2022.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is

information providers send us to give some key information about the service, what the service does well and improvements they plan to make. Feedback of concerns about the service was received from a local authority and a whistle blower and was included in the planning of this inspection.

During the inspection
We spoke with eight relatives, two people who used the service, the chef, two kitchen assistants, maintenance person, four care workers, an activity coordinator, two registered nurses, a visiting nurse specialist, deputy manager and the registered manager who also acted as the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked in detail at eight care plans, five staff recruitment files and the service's staff training matrix. We looked at a variety of records relating to staff recruitment, medicine management, the management of the service, this also included the service's policies and procedures.

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After the inspection
We conducted telephone interviews with one service user, eight relatives, one registered nurse, and two carers after our visit to gather further feedback about the service. We continued to seek clarification from the provider to validate evidence found. All information received was used as part of our inspection.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated Good. At this inspection this key was rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from abuse. The service did not use incidents to always identify potential abuse and ensure all staff were up to date with relevant training to recognise improper use of restraint.
- We observed a person who had multiple visible bruises across their hands and arms. They had dried blood on their head and in their hair. Whilst information about the bruising was within care documentation, no explanation for the cause of their injuries was documented to show staff had taken appropriate action to investigate.
- Staff were not able to provide us with any further information about the injuries and there were no record of the service reporting these unexplained injuries to the local authority's safeguarding team. This practice was not in line with the service's safeguarding policy and procedures dated 16 May 2022 and meant preventative measures were insufficient to protect people from potential abuse.
- Most staff had undertaken the relevant training however, we noted four staff members' safeguarding training had expired earlier this year. There were no records to show what action the service had taken in response to this. This meant people could not be assured staff would be able to prevent and identify abuse when providing care.
- Another person was observed being restrained whilst sitting in a wheelchair. Care records showed on their admission to the service, there was a recommendation for restraint to be used when the person was falling forward whilst sitting in their wheelchair. However, a registered nurse had reported the person had improved and was now able to sit better in the wheelchair and only needed to be supervised.
- The care plan was reviewed and updated but current practice did not reflect the change. During our visit we observed the person calmly sitting in their wheelchair, but the seat belt was on all the time. This meant people could not be confident restraint would be used only when necessary.

We found no evidence people were harmed. However, the service's failure to identify potential abuse, protect people from improper treatment, and ensure all staff's safeguarding adults training was up to date, placed people at potential harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and relatives said they felt they were safe from abuse.

Assessing risk, safety monitoring and management

- People were at risk of potential or significant harm because the registered manager did not do all that was reasonably practicable to mitigate risk of harm.
- Risks were not mitigated for people who were assessed at high risk of falls, as assistive technology was not

always considered. For example, no falls 'crash' mat or sensor mat was in a person's bedroom floor who staff had known had a tendency to try and get out of bed with no assistance. A call bell was not available to enable the person to summon for help.

● The person was tall, and their feet were able to touch the bed base board, increasing the risk of skin pressure damage. A bed and mattress extension were not in place. Staff failed to properly assess the person's risk of skin injury and falls. Care records documented the person was not to be left on their own and nurses should be close by, which we did not observe. We immediately made a referral to the local authority as the person was placed at significant risk of harm.

● Where people had identified risks such as, falls or epilepsy not enough guidance was put in place to reduce the risk of harm. For example, we noted two other people were identified at high risk of falls, their care records supported by our observations showed, no sensor or falls crash mats were placed in their bedrooms to reduce the risk of harm if they were to fall. We noted they spent most of their time in their bedrooms.

● Chemicals used by cleaners were stored on unlocked cleaning trolleys. This included limescale remover (an acid). There was no risk assessment in place for the unlocked trolley, and a chemical data safety sheet was not present for the acid. People who walked with purpose were at risk of ingesting the substances and suffering severe injuries.

● A window on the first floor was not restricted and was able to be fully opened. This meant a person could fall or jump out the window. This was not detected by routine maintenance or health and safety checks. We informed the registered manager so the window could be secured.

● An open storage room door was accessible to people and contained electrical circuit boards which were unlocked and open and placed people at risk of electrocution or ignition of fire.

● Staff were not aware who the fire marshals were and there was no signage to show who the fire marshals were in the event of an emergency. Staff training records showed a lack of regular training in fire safety and fire evacuation drills were not completed regularly. Side gates, which were designated evacuation routes, were padlocked however the key was kept in reception. We informed the fire service of our findings who found insufficient actions were taken to prevent the risk of fire. The registered manager was instructed to address the concerns which were to be completed within a specified timeframe.

● Trip hazards were present in and outside of the building. This included items stored on the floor, such as boxes, packets, moving and handling equipment and linen. The risk of people falling over them was not mitigated.

● A linen cupboard, meant to be locked with a keypad, was open. Inside, linen such as pillows and duvets were piled up against the ceiling. This can interfere with smoke or heat detectors used for fire safety. Despite environmental audits completed, this was not detected and acted on by staff.

Risks to people were not adequately assessed, documented, and mitigated which placed them at risk of avoidable harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Emergency plans were in people's files in the event of an evacuation, such as a fire. They clearly showed how many staff and what equipment the person would need in the event of needing to move from their floor.

Staffing and recruitment

● People, relatives and staff felt there were sufficient staff, but this was not found from our observations. There were insufficient staff to ensure people who required to be closely supervised, due to identified risks, were.

● For example, a person was observed unsupervised, trying to crawl halfway over their bedrails and was

about to fall to the floor before we quickly intervened. Staff were summoned to help the person. After staff left the room, the person attempted the same manoeuvre twice.
● We noted, it was recommended the person was not to be left on their own and registered nurses should be close by. This was not observed.
● We observed inadequate engagement or stimulation for some people on one of the floors. Several people walked with purpose, but staff were busy with other tasks or did not interact with them unless people required care and support, such as medicines or meals.
● The service completed dependency assessments which helped to monitor the overall needs of people. Any changes in peoples' dependency needs would enable the service to assess staffing levels to manage peoples' care and support needs. As of 31 July 2022, there were 11 people assessed at high dependency level.
● However, there were no record to show how staffing levels had been factored into changes in peoples' care and support needs.
● Some staff did not believe staffing levels were sufficient. For a staff member commented, "No, we normally have six (care staff) in the morning and five in the afternoon. The amount of the residents are the same."

There were not enough suitably qualified, competent, skilled and experienced staff to make sure peoples' care and support needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Recruitment practices required improvements. A view of five staff records showed thorough checks were not consistently undertaken. Job application forms were not always fully completed and followed up at the interview stage such as, reasons for leaving previous employment, dates for gaps in employment and full employment histories.

We recommend the service take appropriate action to ensure job applications are fully completed.

Using medicines safely
● Medicines practices were not always safe. The registered manager did not ensure staff followed the service's medicines 'administration of medicines policy and procedures' dated May 2022. For example, the medicines fridge temperatures were not within the required range. They were recorded as too low, meaning the temperature may have damaged the contents which included insulin pens. Staff had recorded no actions taken to ensure the correct storage of the refrigerated medicines. We informed the deputy manager, who liaised with a pharmacist.
● Not all staff who administered medicines had competency assessments completed on a regular basis. This meant their knowledge and skills were not checked to ensure they were safe to continue to manage medicines.
● Skin creams were being shared between different people. Although prescribed for individual use, they were in communal bathrooms and toilets. Incontinence products were also not being used for the correct people for whom they were prescribed by the continence service.

We found no evidence that people were harmed however, people were placed at potential harm as staff did not work in accordance with the relevant policy and procedures. This was a breach of Regulation 12 of (Safe care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Medicines administration records were satisfactorily completed. There were no gaps in the records.
● People's allergies were recorded on the medicine's records. There were recent photographs of people so they could be easily recognised.

● Protocols were in place for 'as required' medicines, such as for mild painkillers.
● Body maps and charts were in place to document where skin creams and lotions were applied to people's bodies.

Preventing and controlling infection
● The service did not do enough to protect people from the risk of the spread of infections. Cleaners had not ensured 'deep cleaning' took place on all relevant surfaces. We found accumulated dust, dirt and debris visible in various areas, including communal toilets, bathrooms and dining rooms. The tops of radiator guards were used as storage points for various items such as people's toiletries, and not wiped under.
● Cleaning trolleys were dirty. Brooms were stored in with garbage in a bag on the side of the trolley. Clean aprons were also stored on the trolley and not in a dedicated storage unit for clean PPE. Some bins were overflowing, even after cleaners had cleaned the units.
● Some staff were found not wearing face masks and others had pushed theirs under their chin. We pointed this out to the individual staff concerned as well as the deputy manager.
● Dry body wipes, meant for use in bedrooms and without soap and water, were located jammed behind taps in communal handwashing sinks. The packet was open and in use.
● Bins were not cleaned and did not always contain bin liners. Toilet brushes were found on the floor in communal bathrooms.
● Washable linen bags with liners were not being used for dirty laundry. Instead, staff used plastic contaminated waste bags tied to linen trolleys. Clean clothes on the trolley were stored in cardboard boxes hanging off the side. This was consistent throughout the building. When asked, staff did not know why this practice had occurred and did not swap to correct dirty linen management.
● Used disposable handtowels were jammed in the handrails throughout various areas in the building. Staff walked past them without removing and disposing of them.
● Personal protective equipment (PPE) was often stored in incorrect places, such as on the top of radiator covers. This increased the chance they were contaminated before staff used them to complete personal care.
● Some sinks were not signed correctly to show they must only be used for cleaning hands. Many did not have handwashing reminder posters located at them.
● Clean cutlery supplies were found positioned on a visibly dirty seat. The cutlery was then used for lunch. Tea and coffee were served from communal jugs which were cracked, worn and dirty.
● Sluice rooms were unlocked despite signage for staff to keep the doors locked. Inside were objects that were a risk to people who walked with purpose, such as chemicals and sharps bins. A sluice room allows for the safe and efficient disposal of human waste. This placed people who had cognitive impairment at potential risk of harm as they could gain easy access. We brought this to the attention of the registered manager but later during our visit, we checked and found some sluice rooms remained unlocked.
● Other rooms which were meant to be closed, were propped open with objects such as water bottle and a cushion.
● Sinks for cleaning mops and mop buckets were visibly dirty. Mop buckets were dirty after use, and mop head (meant to be laundered between use) were stored inside the dirty mop buckets.
● A dirty linen trolley had clean aprons hanging on the side. There was a risk of cross contamination. We pointed this out to staff so they could act. There were cleaners attending to various areas in the units, and there was no malodour.
● A cleaner's room and cleaning trolley were dirty. The trolley shelves were visibly soiled, but stored supplies such as clean clothes were on the shelves. The cleaner stated the trolley was regularly cleaned; however, the housekeeper's cleaning record showed no evidence of the trolley being cleaned. Mops and mop buckets were inappropriately stored. The sink was also soiled.

People were placed at risk of harm from various infections, because hygiene standards were inadequate. This was a breach of Regulation 12 (Safe, care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Assessments of people's needs were not always person-centred. Where people had cognitive impairment such as a diagnosis of dementia, the service failed to develop plans of care documenting, type of dementia, what stage of the disease people were at, how dementia affected their day to day lives, how they would be involved in making decisions about their care. This would have ensured people received specific to their individual care and support needs.
- This meant the individuality of people living with dementia and how their personality and life experiences had influenced their response to dementia, were not considered and there was a potential for people to be discriminated.
- Peoples' individual needs which related to their protected characteristics as identified in the Equality Act 2010, were not considered in the assessment process. For example, preferred language, faith, religion, and cultural considerations. This would ensure they were not discriminated against.
- Plans of care developed from information gathered from admission assessments did not always capture people's life stories. This would have enabled staff to have a better understanding about the people they cared for, which would then enhance people's experience of care.
- Relatives spoke about their involvement in and experience of the admission assessment process. Comment included, "We had lengthy meetings (with staff) when she was admitted to the care home to discuss her needs", "(Family member's) likes and dislikes were given in the past and questions were asked about her on admission", "I had an assessment meeting arranged this week, but when I arrived a nurse told me I would have to be quick because they needed to help with lunch, they knew nothing about my mother and wanted to hold the meeting at the nurses station with constant interruptions, the meeting is now rearranged for next week" and "I have never been asked about (family member's) likes and dislikes, there has been no assessment. I have not been given any information on admission about the need to name his clothes etc." This meant there was a potential for some people's care and support needs and preferences not to be met due to the inconsistency in the admission process.

The service did not always do everything reasonably practicable to make sure people who used the service received person-centred care. Assessments did not always take consider current legislation and how the service worked collaboratively with people and their relatives during the assessment, was not consistent. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

- Admission assessments gathered information about the peoples' physical and mental health,

communication, and social history. 'Windsor Care Residents preference' forms documented people's preferences such as what time they liked to get up in the mornings, whether they liked to bathe or shower and preferred times to see visitors, as examples. Diet notifications sheets captured peoples' preferences for breakfast, lunch, and dinner.

Staff support: induction, training, skills and experience

● People received care and support from staff who were inducted and supervised but who were not appropriately trained.

● Training records for 2021 and 2022 showed the Care Certificate modules were being used to record staff initial and refresher training. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

● For staff that provided personal care, few had completed training topics to manage high risks. For example, most staff who supported people had not completed falls prevention, manual handling, medicines management and food hygiene safety. There were only two staff recorded as trained in first aid.

● Most ancillary staff had completed little training relevant to their role. For example, two staff had completed food hygiene training. We found cold breakfast in a hot trolley on one floor during service, and that the kitchen was not recording breakfast food temperatures before the trolley left the main preparation area.

● There was no record of training for staff in complex or long-term conditions. Examples included the safe management of diabetes, basic principles of caring for people with dementia, and effective management of diseases such as Parkinson's.

● Some staff we spoke with told us they were not supported to increase their knowledge and skills relevant to providing effective care for people. For example, they told us there was a lack of training in manual handling and use of equipment. Furthermore, there was a lack of specialist training on how to manage people living with dementia, delirium and mental health issues. Staff records and the service's training matrix confirmed this.

● One staff member stated they were "deskilled" in their role and were intending on resigning due to lack of investment in their training by the service.

● The registered manager acknowledged staff training was an area that required improvement and told us they were in the process of looking for another training provider.

Staff were not always supported to undertake training, learning and development to enable them to fulfil the requirements of their roles. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People who had poor mobility did not always receive effective care. Where people received support and input from physiotherapists, care records did not always reflect how physiotherapists' recommendations were implemented into people's plans of care. For example, there were no clear exercise plan or regime for care workers to continue rehabilitation on a regular basis.

● There was no evidence physical activities or strengthening exercises considered beneficial for people with poor mobility to improve flexibility and help with balance and coordination.

● People living in the service were required to have annual health checks and medicine reviews by GPs. The registered manager was unable to show us these were regularly undertaken. This meant people could not be assured the service would always work with healthcare services, to help them live healthier lives.

People with poor mobility were not always effectively supported. Reviews of peoples' health were not regularly undertaken and information from health care professionals supporting people, were not always considered. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Where people with poor mobility had been discharged to the service on a temporary basis from hospital and had physiotherapist or occupational therapist input. We saw records of notes of their session notes.
● Other healthcare professionals such as podiatrists, tissue viability nurses, occupational therapists and tissue viability nurses were involved in people's care, when required.

Adapting service, design, decoration to meet people's needs
● Furniture in peoples' rooms was visibly soiled and stained. The fabric materials of recliner chairs were not regularly shampooed or replaced. Some footstools were seen tipped over in people's bedrooms.
● An outside area used by people for smoking was strewn with rubbish. This was on the ground and on the tables, they sat at. Staff later cleaned this area once we pointed this out to them.
● Storage shelves in some communal bathrooms contained items that placed people at risk of harm. This included bottled perfumes and cans of air fresheners.
● Storage in the linen rooms was insufficient. Clean linen such as duvets, sheets and blankets were stored on the floor due to lack of space.
● Kitchenettes contained insufficient storage for cups, tins, bottles and boxes of food and drink. The kitchenette benches were worn and bare in places.
● A wheelchair was found partly assembled in one area, with foot plates and handrails strewn across the floor. A further seven wheelchairs were found unsafe for use, with missing footplates, other missing parts and brakes that did not function. A standing hoist had a rusted through foot plate. We informed the deputy manager and registered manager who organised for repairs and replacement. Although staff knew about the faulty equipment, they had not escalated this.
● There was a sensory room, but the door was locked. For people who walked with purpose and others living with dementia, they could not enter on their own.

There were not suitable arrangements in place to ensure the premises and equipment were promptly maintained. This was a breach of Regulation 15 (1) (e) Premises and equipment of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The registered manager showed us an up-to-date list of which people had DoLS authorisations, which had expired, those due for renewal. However, when we asked whether they had followed up outstanding assessments with various local authorities, they said they had telephoned them about people's outstanding DoLS applications. There was no written evidence that the service's staff had checked the ongoing of people's DoLS status on a regular basis.

We recommend the service implements a plan to check people's DoLS application statuses at regular intervals.

● Staff on both floors unit were not always aware of which people had a DoLS authorisation. For people who had DoLS authorisations in place, some staff could not explain why the person's liberty was deprived.
● Some 'do not resuscitate' orders, a treatment that can be given when a person stops breathing or when their heart stops beating, on file were from hospitals and were not completed at the service. Many were out of date and were not reviewed or reviewed infrequently. This meant people or those who hold legal power on their behalf, could not be assured their preferences regarding this treatment, would be followed.
● Mental capacity assessments were completed where a person's ability to make a certain decision might be impaired. Examples included for types of restraint, such as bedrails. Record keeping in some examples was insufficient. Staff had failed to record whether a person had an enduring or lasting power of attorney, an appointed advocate or if a Court of Protection order was in place. The administrator had a list of these, but they were not readily available in people's care files.
● Consent was not always obtained or established correctly. A person lacking capacity to consent was recorded with the relative as the 'decision maker'. They did not have the right within the MCA to make the specific decision. Another relative had signed a consent form for a person; again, they did not have the legal authority to consent on behalf of the person.
● Best interest decisions were documented, but the involvement of significant others, such as relatives, was not always included.

The registered person failed to ensure consent was correctly established in accordance with the Mental Capacity Act 2005. This was a breach of Regulation 11 (Consent) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● Meals were offered to people, but staff did not always provide them with a choice. For example, at lunch time, we observed on one of the units, food was placed on a plate and put in front of a person. They were not always asked what they would like to eat or offered alternatives to what was already prepared.
● Some people were either rushed to finish their meal, with staff taking it away before they were finished. In other instances, staff did not pay attention to some people who were struggling to consume their food and drink independently.

We recommend the service make sure all staff are aware of the importance of offering people a choice of meals and they have enough support to enable them to have adequate nutrition and hydration.

● People and relatives spoke positively about how the service met their nutritional and hydration needs. Comments included, "My mother has little appetite, she doesn't want to eat, but she does seem to maintain her weight, she has put on weight since she has lived (at the service)" and "Food is provided to suit (family member's) wishes, she is given a choice, she is unable to feed herself so the staff help her to eat."
● Observations on another unit showed people were offered a choice of meals and staff waited patiently for them to decide, staff engaged positively with people and were heard encouraging people in a caring way to

eat and drink.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection this key question was rated good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The service did not always promote an open, empowering and inclusive work culture. Staff spoke about the culture of the workplace. Although some staff spoke positively about the registered manager and deputy manager, describing them as, 'approachable', 'accessible' and 'supportive', other staff members expressed their dissatisfaction with the management of the service.
- The service had sought feedback from relatives and staff in June and July 2021. Most of the feedback received from relatives and staff were positive, expressing how well-led the service was. However, not all feedback had been responded to or acted upon promptly.
- For example, a staff member had commented about the service needing to review the cleaning services for peoples' safety and another staff member had requested the need for face-to-face training in new manual handling techniques, challenging behaviour, and infection control. The registered manager gave no response to the feedback about cleaning and stated due to the pandemic, all training would be held online.
- During our inspection we found several safety concerns around cleanliness, infection control practices and staff training. The government's COVID-19 restrictions were lifted on 19 July 2021 with minor restrictions kept in place. However, the registered manager had failed to act promptly to ensure staff received the essential face to face training and an appropriate cleaning regime was in place.
- The registered manager informed us due to the pandemic staff meetings were stopped but were due to restart shortly. This was confirmed by staff who had expressed concerns about not having the opportunity to be listened to.

There were ineffective communication systems and missed opportunities to improve the quality of the service for people and staff, after feedback was sought. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People gave positive feedback about the service and said they had no complaints. This was supported by some relatives were also positive about the service and felt it was well-led based upon their interactions with care staff and the deputy manager.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Quality assurance systems used to assess, monitor and improve service delivery were inadequate. There

was a lack of scrutiny and oversight at board level senior management to ensure established quality assurance systems remained effective and the registered manager, who was also the nominated individual for the service was meeting regulatory requirements.

● Minutes of 'Governance Oversight Group' meeting held on 12th February 2021 and 7 May 2021 showed board members viewed the findings of quality assurance audits. However, quality assurance audits were not thoroughly interrogated.

● For example, safeguarding audits presented to the board members documented safeguarding incidents that had happened during a particular period but only showed they had been closed. There was no information to show if any allegations of abuse were partially or fully proven. Therefore, there was no opportunity to look at what lessons had been learnt as a result. This would have ensured peoples' safety was not compromised.

● We noted the last 'Governance Oversight Group' meeting was last held 16 months ago, which meant there was no opportunity to review and respond appropriately to shortfalls without delay.

● The registered manager and the staff designated to conduct managerial tasks such as, audits, assessments of peoples' care needs and risks, had not received role specific training to enable them to carry out the relevant tasks.

● For example, the service had several people who were living with dementia and some who had mental health conditions. There were no plans of care specific to these conditions, to enable to staff to understand more about the types of dementia, what stage of the disease people are at and how that could affect their behaviour. Where people had mental health conditions, these were only noted in care records without any plans of care specifically related to those conditions. This shortfall had not been identified through the provider's audits.

● The registered manager had received recognition as a 'Dementia Capable Society Leader' in September 2016. This meant they were committed to creating a dementia capable society where people living with dementia, could live to their functional and emotional potential and be empowered. This was not seen in care records viewed and our observations.

● Staff were passionate about their jobs but were not upskilled and supported to provide care at regulatory standards. For example, the level of training offered to care staff (including activity coordinators) about dementia was at an awareness level. We noted some staff had worked for the service for several years and therefore their learning would need to be at an advanced level.

● People and relatives felt further improvements were required. The service had a schedule of activities for people held from Mondays to Fridays, with no activity schedules in place for people who were not able to leave their rooms and there no scheduled activities at weekends.

● Records relating to care and the management of the service were at times, eligible, inaccurate, not fully completed and not fit for purpose. Records did not indicate how people or relatives were involved in the admission assessment process. Falls risk assessments and falls management plans were generic, not person-centred and lacked essential information to show what actions were taken by staff over a period of time for people who had repeat falls, as an example.

●Where people had been admitted to the service from the hospital for a temporary period, not enough due care and attention was taken when developing their plans of care. For example, one person's care record was just written on a document not relevant to their care, they were written in an uniformed way and was 'scrawled' across the page. This made it and difficult for us to understand all the person's care and support needs and meant they could potentially not receive the required care and support.

● Completed satisfaction surveys for relatives and staff failed to record how many surveys had been sent and how many completed responses were received. This would have enabled the service to look at different ways of ensuring all views were captured and responded to. Staff rotas did not give a description of the codes used to indicate what shifts staff members were allocated to and, training and supervision matrixes were not regularly updated. This would have enabled management briefly, to see staff training needs and

what training had expired.
● The registered manager failed to keep a record of when they contacted local authorities when following up on expired DoLS. Where people required physiotherapist intervention, there was no formal referrals forms used to evidence who was referred, when, the outcome and whether rehabilitation exercise plans were incorporated into peoples' plans of care. The registered manager sent us two minutes of staff meetings that were held with the deputy manager on 3 and 4 August 2022. The minutes did not record the actual comments made by staff relating to the topics discussed. Therefore, could not be of assured of the accuracy of the minute notes.
● The service failed to put appropriate measures to reduce or remove identified risks within a timescale that reflected the level of risk and impact on people using the service who were at risk of choking, epilepsy, falling, as examples.
● Audits of care plans failed to pick up on what we had found and appeared to be a 'tick box' exercise. This was because the registered manager and deputy manager failed to record whose care plan had been audited and specify timescales for when required actions should be completed and, by whom. The service conducted various audits of, medication records, infection control, medicine records, infection control, kitchen audits and housing keeping audits. These were not able to identify any of the concerns found during our inspection.

Quality assurances systems in place were ineffective. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Prior to our inspection ratings poster was clearly displayed in the building's entrance, and on the provider's website.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
●The CQC sets out specific requirements that providers must follow when things go wrong with care and treatment. This includes informing people and their relatives about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
● Although duty of candour letters was sent when things went wrong with care and support. The registered manager would need to ensure this was consistently completed in a timely manner, and they work in accordance with all aspects of the legislation.

We recommend the registered manager ensure work practices are in line with its Duty of Candour Policy.

Working in partnership with others
● There were regular reviews of people's health and social care needs by community-based professionals but more improvements was required to show how this resulted in good outcomes for people, especially those with poor mobility and living with dementia.
● The service worked in partnership with other health and social care providers and local authorities. A location confirmed this.
● A visiting specialist nurse told us that the registered nurses and care workers worked well with them when they were conducting reviews. They commented that people's documentation upon discharge from hospital required some improvement to ensure they could carry out their role effectively. They stated they were not provided with a list of people at the service, so they knew which required a review. We informed the registered manager who said the nurse could access a list each time they visited in the future.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service did not always do everything reasonably practicable to make sure people who used the service received person-centred care. Assessments did not always consider current legislation. People with poor mobility were not always effectively supported. Reviews of peoples' health were not regularly undertaken and information from health care professionals supporting people, were not always considered. Regulation (9) (1), (3), (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person failed to ensure consent was correctly established in accordance with the Mental Capacity Act 2005. Regulation (11), (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service's failed to identify potential abuse, protect people from improper treatment, and ensure all staff's safeguarding adults training

was up to date.

Regulation 13 (2) (4) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Insufficient decoration and refurbishment of the building and premises, and failure to manage equipment and storage satisfactorily placed people at risk. There were not suitable arrangements in place to ensure the premises and equipment were promptly maintained. Regulation 15 (1) (a) (b) (c) (d) (e) (f).