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Windsor Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place over three days, 9 and 11 May and 4 June 2016. All aspects of the inspection were unannounced. This meant that staff and the provider did not know that we would be visiting. We last inspected the service on 21 May 2014 and found that they were meeting the standards that we inspected against at that time.

Windsor Care Home is a residential and nursing home that provides care to older persons and people who may be living with a dementia. It can accommodate up to 73 people. At the time of our inspection 63 people were living at the home.

The registered manager has been registered with us since 1 October 2010. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the inspection we found that the service had breached a number of regulations. People did not receive care and support in line with assessments to ensure that associated risks were managed and care was delivered safely. People were not protected against the risks associated with infection due to the service failing to adopt and implement appropriate infection prevention and control measures. People's hydration and nutritional needs were not being managed in a way that was safe and promoted their health and well-being.

The service failed to deploy enough staff across the home in order to safely meet the needs of people who used the service. Staff that were employed at the service had not been subject to robust recruitment processes and checks. Staff had not completed the appropriate training to enable them to carry out their roles effectively.

The service failed to protect people from abuse, or allegations of abuse. This was because there was not a sufficiently robust system in place to ensure that relevant authorities were made aware of allegations of abuse. This also meant that there were insufficient systems in place to prevent further abuse or allegations occurring.

Staff did not understand or act in accordance with the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS), which meant they failed to act lawfully to support people who lacked capacity to make their own decisions.

Medicine administration was not always carried out safely. Appropriate arrangements for the ordering and supply of required medicines were not in place. Medicines were found to be out of stock and care plans did not reflect or support the administration of medicines that was required.

Appropriate checks of the building and maintenance systems were undertaken to ensure risks to people's health and safety were minimised.

The service did not promote a culture that was open, inclusive and empowering. There was a lack of confidence from people, those acting on their behalf and staff, in the process of raising concerns and issues with the service. The process that was in place to monitor the on-going quality of the service was ineffective.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

The service 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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The care and treatment needs of people who used the service were not assessed and monitored. This meant that care planning did not always reflect the needs of people who used the service.

Medicines were not always managed safely for people and records had not been completed correctly. People did not receive their medicines at the times they needed them and in a safe way. Medicines were not administered and recorded properly.

The service failed to protect people who used the service from abuse or improper treatment whilst receiving care and treatment. The service did not have robust processes or procedures in place to safeguard people for the risk of abuse. Where abuse was discovered or suspected, the service failed to take appropriate action, without delay, to investigate and refer the incident to the appropriate body.

The service failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service. Staff did not receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities.

The service failed to implement robust recruitment procedures to ensure that staff were suitable for the role in which they were employed.

Is the service effective?

Inadequate

The service was not effective.

Staff were not supported to attend training that was relevant to the needs of people who used the service. Staff competencies were not monitored and staff were not supported by management through a robust supervision and appraisal process.

People who used the service had access to healthcare services and received on-going healthcare support.

Consent to care and treatment was not sought in line with legislation and guidance.

The service failed to ensure that the nutrition and hydration needs of people were met by way of appropriate support enabling them to have sufficient to eat and drink.

Is the service caring?

Requires Improvement

The service was not caring.

Staff did not always understand the care and treatment needs of people who used the service. Observations were that staff were very busy and were not afforded the time to engage with people who used the service, to better understand their needs, wishes or preferences. We did see that some positive, caring relationships had developed between some members of staff and people who used the service.

People's privacy and dignity was not always respected and promoted. People were found to be isolated during the delivery of their care and treatment needs with very little social interaction.

People were not supported to express their views or be actively involved in making decisions about their care, treatment and support.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive personalised care that was responsive to their needs. Planning and delivery of care and support was not person centred and did not focus on assessed needs. People's needs were not subject to regular review to ensure care remained responsive to the needs and wishes of people who used the service.

The service did not listen and learn from people's experiences, concerns and complaints. The service had a complaints procedure in place that was accessible to people who used the staff, but people told us they did not have confidence in approaching the management team as they did not feel that they would respond appropriately to concerns raised.

Is the service well-led?

Inadequate

The service was not well led.

The service failed to promote a positive culture that was person-centred, open, inclusive and empowering. People who used the service and staff did not have the opportunities to become involved and suggest ways in which the service could be improved.

Management had failed to implement and carry on robust quality monitoring processes to assess the quality of the care, treatment and support that the service provided.

Windsor Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place over three days, on 9 and 11 May and 4 June 2016. All elements of this inspection were unannounced.

Four adult social care inspectors carried out the inspection. In addition they were supported by a pharmacy inspector who carried out a full inspection of the medication processes that were in place within the service.

Before the inspection we reviewed information we held about the service. This included previous inspection reports and statutory notifications sent to us about the events and incidents that happened at the service. Notifications are changes, events or incidents the provider is legally required to let us know about. We contacted the Commissioners of the relevant local and health authorities and the local safeguarding authority before the inspection to obtain their views of the services delivered at this home and gather intelligence about the delivery of care and treatment.

During the inspection we spoke with 16 people who used the service and five relatives or friends who were visiting the service. We also carried out observations across the whole home to capture the experiences of those people who we were unable to speak with directly. Over the course of the inspection we spoke with 29 members of staff, including the registered manager, deputy manager, administrators, nurses, senior carers, care assistants and domestic staff. We also spoke with one visiting healthcare professional.

We reviewed a range of records about people's care and how the home was managed. These included care records relating to 13 people, medication administration records relating to fifteen people, recruitment records relating to six employees (all who were employed to deliver care), training records relating to 51 employees and quality monitoring reports carried out by management since January 2016.

Inadequate

Is the service safe?

Our findings

We found care records did not accurately reflect the current needs of people who used the service. We found care needs were not always appropriately assessed and reassessments were not carried out in line with the homes policy of every three months, or when changes occurred. For example, we found one person had been admitted to hospital for further care and treatment. The home did not reassess the needs of this person prior to discharge from hospital, in order to assure that they could continue to safely and effectively meet their needs.

In one instance, where records did reflect the current needs of individuals we observed the planned care was not being delivered by staff. For example, we found the person had been assessed by specialist healthcare professionals as requiring specific support with eating and drinking. This information had been captured in the plan of care but our observations demonstrated that this care and support was not being delivered by staff. This meant that people were not receiving care and support in line with assessments to ensure that associated risks were managed.

We spoke with staff about the care needs of people who lived at the home. Staff were not knowledgeable about the current care and support needs of people who used the service. We spoke with two nurses about the specific needs relating to one person who lived at the home. When we asked specific questions about their care needs, questions which we would reasonably expect nursing staff to be able to answer, they told us that they were unsure of the treatment regime's and that we would need to speak with the deputy manager. Another example included staff being unaware of advice provided by external healthcare professionals. For example, people had been assessed as requiring positional changes at frequent intervals, in order to help promote and maintain their skin integrity. We found that documentation did not reflect this care need being carried out for two individuals. When we spoke with staff, they were unaware of the need for positional changes to be carried out. This meant that people were at risk of receiving unsafe care and treatment.

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

We saw the home did not have effective processes to ensure safe care was delivered where people were living with an infection. For example, we saw staff failed to adopt appropriate hand hygiene practices when preparing to deliver care and support and following delivery of care and support. We observed staff walk around the home and go in and out of people's bedrooms to offer care and support without changing the disposal personal, protective equipment (PPE) they were wearing. In one person's bedroom we saw that crockery and cutlery was being piled up in a sink and that the general cleanliness of the room had not been addressed. This meant that people were not protected against the risks associated with failing to adopt infection prevention and control measures.

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

The home is divided into four separate units, located over two floors with two units per floor. On the first day of the inspection we found that the atmosphere in the home was chaotic. Staff were extremely busy and call bells rang almost constantly. When we spoke with staff they told us they were short staffed due to people who were known to be unavailable for work being included on the staff rota.

We carried out a number of observations on days one and two of the inspection. We saw that people were waiting for prolonged periods of time for care and support to be delivered to them. For example, we saw one person wait for 35 minutes, from their initial request for breakfast to be served. At various points throughout the observations we saw that only one member of staff was available to supervise 12 people who were sitting in the communal lounge.

In discussions with staff we found that some non-care staff were working in the capacity of carers in order to support colleagues. One member of staff we spoke with said, "We only have five members of staff up here today, there is supposed to be more but three are on the sick". They went on to say, "In all honesty we often work with only two on this unit. We have quite a few [service users] who require 2:1 support for all transfers so we have to arrange for one of the others to come over [from another unit] otherwise we have to leave people on their own, unsupervised."

We carried out lunch time observations and saw that some people waited for over 25 minutes, from the point of being seated in the dining room, for lunch to be served. During this time one person shouted, "Come on, are we not getting fed today or something", another person said, "What is happening with my tea?"

We spoke with the registered manager about how they determined the staffing levels needed across the home. They told us they used a dependency assessment tool, which considered the assessed needs of people who used the service, to determine staffing levels. They informed us that this tool had not been utilised for over a year and that staffing levels had remained stagnant. Throughout this period the home had undertaken an extension which had increased capacity by almost 50%. This meant that the service failed to deploy enough staff across the home in order to safely meet the needs of people who used the service.

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

We looked at the recruitment files of six members of staff. We found that each member of staff held a disclosure and barring service (DBS) certificate. Some of these certificates had transferred from previous employment or were in some instances over three years old. We asked the registered manager how they managed risks associated with not carrying out these checks more frequently. She told us that they had not considered this other than to request that staff inform them of any changes to their criminal record. She went on to add that the provider was in the process of renewing DBS checks for all staff.

Two of the recruitment files we looked at did not contain satisfactory evidence of conduct in previous employment. Three of the recruitment files did not contain appropriate identity checks. This meant that the recruitment process and checks associated with ensuring safe recruitment, was not robust.

This was a breach of Regulation 19 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

We spoke with the registered manager about safeguarding referral procedures. They provided us with copies of safeguarding consideration logs they were retaining due to on-going work with the local authority. We

identified 13 incidents that were recorded on these logs and found that seven of these were being managed through internal processes. These seven incidents met the safeguarding threshold criteria for referral to the local authority safeguarding authority who carry out independent investigations. This meant that there were not sufficiently robust systems in place to ensure that relevant authorities were made aware of allegations of abuse. This also meant that there were insufficient systems in place to prevent further abuse or allegations occurring.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the safeguarding processes within the home. We found the home had a safeguarding policy that was accessible to staff. Staff told us they were aware of the safeguarding policies and were able to describe what action they would take if they felt people were being abused or at risk of abuse.

During our inspection we looked at the arrangements for the management of medicines. We looked at how medicines were handled and found that the arrangements were not always safe.

Medicine Administration Records (MAR) were not completed correctly, placing people at risk of medication errors. Medicines were not stock controlled; no records were kept of incoming medicines or what stock levels of medicines were being carried forward to the next administration cycle. This is necessary so accurate records of medication are available and care workers can monitor when further medication would need to be ordered. For medicines with a choice of dose, the records did not always show how much medicine the person had been given at each dose, these records also did not demonstrate why a particular dose had been administered.

We found that the application of some topical medicines had been delegated to care workers. Although the home had a policy stating there should be a care plan in place and a daily account should be made of the application, the guidance we saw was incomplete and the recording of the application of these topical medicines was poor. For one person, described as having red sore skin, we saw no records of application of a prescribed barrier cream. For another person, care staff described applying a barrier cream but we saw that no records had been maintained. For another person, a cream was listed on their medicine administration record (MAR) but there was no care plan or guidance in place to inform staff where and when it should be used. These records would help to ensure that people's prescribed creams and ointments were used appropriately. Staff told us they were still working on improving these records and ensuring they were always completed. This meant we could not be sure that people were receiving their prescribed topical medicines.

We checked a sample of medicines alongside the records for 11 people; we found that 19 medicines for eight people did not match up so we could not be sure if people were having their medication administered correctly.

Five medicines that were prescribed for five people were not available in the service. This demonstrated that appropriate arrangements for ordering and obtaining people's prescribed medicines were failing, which increased the risk of harm.

We looked at the guidance information kept about medicines to be administered 'when required' (PRN). Although the home's policy stated, 'that a specific care plan for 'PRN' medicines should be kept with the MAR chart', we found this was not kept up to date and information was missing for many medicines. This information would help to ensure people were given their medicines in a safe, consistent and appropriate

way. For example, one person was prescribed a medicine that could be used for agitation. There was no care plan in place to assist care staff in their decision making about when it would be used. For another person the prescribed dose had changed but the guidance had not been updated to reflect this.

These findings evidenced a breach of Regulation 12 Heath and Social Care Act (Regulated Activities) Regulations 2014 (Part 3).

Medicines were kept securely. Records were kept of room and fridge temperatures to ensure they were safely kept. Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Additional records were completed and retained relating to the usage of controlled drugs so as to readily detect any loss.

Records we looked at confirmed that checks of the building and equipment were carried out to ensure risks to the health and safety of people, staff and visitors were minimised. Relevant checks had been carried out on the boiler, fire extinguishers and portable appliance testing (PAT) available throughout the service.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that 45 amount of people at the home were subject to a DoLS at the time of this inspection. We reviewed the documentation relating to this and found that they had all been authorised by the local supervising authority.

We had specific discussions with the registered manager about the capacity of one person as a Deprivation of Liberty Safeguards (DoLS) application had been submitted. They registered manager said, "I think they have capacity." They then went on to say, "I automatically put one in anyway, I would rather the Local Authority checked and said no." The registered manager had submitted a deprivation of liberty application, without following the process for assessing capacity, having discussion with the person and whilst believing they had capacity. This was not a proportionate response and was not in accordance with the Deprivation of Liberty Safeguards: Code of Practice and the Mental Capacity Act 2005: Code of Practice. Such actions could result in people being deprived of their liberty unnecessarily and without due consideration of the least restrictive option.

We found that no one employed at the home had undertaken training on the Mental Capacity Act 2005. Staff we spoke with did not demonstrate that they were knowledgeable about the principles of the Act and told us that as a result of this they were not completing capacity assessments as and when required.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did observe that staff routinely asked for and obtained verbal consent from people who used the service when engaging them in care and support.

We requested the training records relating to all staff employed at the home from the registered manager. We were informed that this information was collated centrally in a training matrix. A review of the training matrix identified that training requirements of only 51 employees were captured, this was despite a staff list, which the registered manager provided to us, identifying that there were 91 staff employed at the home. No

explanation was offered by the Registered Manager as to why this discrepancy had occurred.

Of the 51 staff (100%) named on the training matrix only 41% had completed moving and handling training; 41% had completed health and safety training; 8% had completed basic first aid training with 33% having completed specific training in cardio pulmonary resuscitation (CPR); 41% had completed fire awareness training; 12% had completed training in delivering effective end of life care; 8% had completed training around the deprivation of liberty safeguards. Despite the home having two dedicated units for people living with a dementia only 16% of employees had completed training in dementia awareness; 8% of employees had completed training in diabetes awareness; 10% of staff had completed safe handling of medication training; 6% of staff had completed training relating to the promotion and management of nutritional health; 37% of staff had completed safeguarding vulnerable adults training and infection prevention and control training and 31% had completed training on delivering person centred care. We were unable to ascertain the training completed by the remaining 40 staff that were not included in the training matrix.

At the time of the inspection the home were caring for people with a wide range of needs, including end of life care, people living with a dementia, people living with diabetes and people who had been assessed as at risk of malnutrition. This meant that people who used the service were not being supported by staff with the necessary skills and knowledge to deliver safe and effective care. Furthermore, the home had failed to capture all staff on the training matrix which meant that we could not ascertain the true extent of this breach of regulation.

Following discussion with the registered manager, we found that the home had failed to implement a process to effectively manage, monitor and assess the competencies of all staff. This meant that despite staff receiving partial training in some areas, there were no mechanisms to ensure that the training was appropriate and to ensure staff were confident and competent in the delivery of care. This finding also extended to registered nurses employed by the home, who were not having their clinical competencies evaluated.

We looked at the induction process for six members of staff who had been employed within the last 12 months. We found that the policy was for new staff to be placed on an initial three month probation. We found that the induction process itself was completion of a booklet containing a variety of training tasks designed to ensure that staff were appropriately skilled and ready to safely deliver care.

We found that four of the six staff files reviewed demonstrated that staff had not completed the induction ahead of commencing their first unsupervised shift within the home. This was of particular concern given that two of the employees were found to have gained employment in the home straight from education with no prior employment in the care sector. We spoke with the registered manager who could not provide an explanation as to why the induction had not been completed. They advised that they met with staff on a regular basis throughout the probationary period but did not produce any evidence of this occurring. Two members of staff we spoke with, who had surpassed the probationary period, said that they had not met with management since they had commenced employment and had not spoken with them since their initial interview.

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

Of the care records reviewed we found that a number of people required support and assistance to maintain a good nutritional and hydration intake. Admission assessments and care records indicated that one person had difficulties swallowing and required a special diet and support with eating. We saw that assessments

shared by external healthcare professionals, Speech and Language Therapy, stated that this person was at high risk of aspiration and as such needed supervision when eating and drinking and required specific food and fluids to meet their needs. We found this information had been utilised by the home when planning the care of this person and the care plan was explicit in stating they must be supervised. During our inspection we found this person was eating breakfast in bed, unsupervised. This meant that staff had failed to implement the recommendations of healthcare professionals and were failing to mitigate the risks of aspiration and choking.

Admission assessments and care records indicated that another person had difficulties swallowing and required a special diet and support with eating. The external healthcare professionals had also assessed the need for this person to have a specific diet to address their nutritional intake requirements. The care plan did not reflect this advice. When we spoke with staff they were unaware of the specific requirements relating to this persons diet. The admission assessments and care plans did not reflect the information that was shared from the hospital following this person's discharge. This meant we could not be assured that this person was receiving suitable and nutritious food which was adequate to sustain life and good health. It was unclear if this person was receiving the care and treatment that had most recently been assessed and deemed appropriate by medical professionals.

Where people were found to have their nutritional and hydration needs monitored we found that where they failed to reach set daily targets the home failed to address this and consider any additional action that may be required to support the achievement of these targets.

We found that weight charts retained demonstrated that weights were not recorded weekly for those people that had been assessed as requiring weekly monitoring. The last record retained was dated 2 April 2016. We spoke with staff about this and they told us that the weight scales had been out of use since March 2016. During the eight weeks leading up to our visits were saw that no action had been taken, by the registered manager or the provider, to have the scales repaired or to make provisions for the purchase of new scales.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did find that where appropriate people had access to external healthcare professionals to support their health and wellbeing. We saw that when people were unwell, GP's were contacted and if necessary home visits were arranged. During our inspection we saw that healthcare professionals, including district community nurses, were visiting people who used the service.

Requires Improvement

Is the service caring?

Our findings

We observed care and support practice within the home where people were living with a healthcare associated infection (HCAI). During our first day of inspection we observed staff on duty discussing how they would manage those people's mealtimes and how they could present meals to them without needing to remain in their bedrooms and in the person's presence for a prolonged period.

On the second day of our inspection we were informed by people and their relatives that they had received limited contact with staff since being discharged from hospital. We observed staff knocking on the bedroom door and passing meals through the doorway to relatives and advising if anything further was required to press the call bell. This meant that people were not treated with dignity and respect at all times whilst receiving their care and treatment. As a direct result of people contracting an HCAI they were not being treated as an equal. They were being isolated despite the fact that people colonised with an HCAI do not usually present a risk to other people in their community and should continue with their normal lives without restriction or isolation (Department of Health: Prevention and control of infection in care homes, guidance issued 18 February 2013).

This was a breach of Regulation 10 of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014.

People who used the service told us that they were happy with the care and support that they received. One person said, "The staff are so helpful", another person said, "They (staff) all know what they are doing." One relative we spoke with said, "I can only comment on our experience but it has been nothing but good. The home is clean and does not smell, they (staff) are all lovely." Another relative we spoke with said, "We chose this home because of its reputation. It had a really good reputation, but we have not been impressed. I don't know if it is because it is bigger now, but I constantly have to speak with the manager and then ask why nothing is being done."

Our observations showed that some staff had developed positive caring relationships with people who used the service. We saw laughter between staff and service users despite the atmosphere being very hectic at times. Staff shared jokes with people who used the service and tried to engage them in conversations about their family and how they had spent their days. We saw the people who used the service were familiar with staff, one person said, "I know you, you've helped me before, I need your help again".

We observed two staff members support a person out of their chair, they were patient and calm. They encouraged the person to be independent but talked through every step of intervention and support. They used non-verbal ques as encouragement and the whole interaction was very positive.
We saw that staff had awareness of people's individual needs, for example we saw a person talking with a staff member. The staff member recognised that the person was struggling to hear them and prompted them with support to turn up their hearing aid.

Staff encouraged people to reminisce and were talking about their family and asking about their previous

jobs. Staff clearly knew people as they were prompting them to remember certain things for example we saw them saying "Didn't you used to teach?" to someone who was a teacher in their working life.

Inadequate

Is the service responsive?

Our findings

On the first day of our inspection we spoke with the registered manager about work that they had been undertaking to improve the care planning within the home. This work was undertaken following recent inspections by other authorities. The registered manager advised that care planning had been reviewed and that they, as manager of the service, were satisfied that care plans were up to date and reflected the current needs of all people who used the service.

We looked at the care records relating to people who used the service. The care records we reviewed did not demonstrate that people's needs were assessed or that their care was planned and delivered in line with their individual needs. Individual choices and decisions were not always documented within these records and we found that the records were not subject to regular review, or as people's needs changed.

Care plans were not person centred. Person centred planning is a way of helping someone to plan their care and support, with the focus on what is important to the person. Care records did not contain relevant and appropriate information relating to current health and social needs. They did not contain past histories (both health and social). This meant staff did not understand what had affected people's lives or continued to affect their lives.

One person's care records stated that they needed full assistance from two staff using specific transfer aids (these aids are used to make physical transfers safe and comfortable) and that staff were to ensure all steps of the care intervention were explained to the person. There was further information documented which referenced risks associated with this care intervention. This stated that the person had a history of challenging behaviour and set out the health issues that the person lived with. This document was dated 23 April 2016.

Other care records relating to this person stated they required full assistance from two carers and although it detailed transfer aids that were required, these were different aids to those detailed within the document dated 23 April 2016. This document had last been reviewed as being accurate on 30 April 2016. These records contained conflicting information as to the support this person required with moving and handling. In addition, the care plan for moving and handling was not personalised for the person and was not accurate in addressing the risks associated with transferring the person.

Following a review of correspondence dated 23 April 2016, we found that the home had failed to implement or act upon the advice and recommendations of external healthcare professionals in reference to the care delivery of this person.

The care planning was not supported by appropriate consideration of risks that were identified, such as the challenging behaviours and health issues, and actions required to mitigate these risks. This meant it was not possible to ensure that people received safe and appropriate person-centred care and treatment that was based upon their assessed needs.

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

The service had a complaints process that was accessible to people who used the service, others acting on their behalf and staff. The process contained assurances that any concerns, comments or complaints raised would be considered, investigated and responded to within prescribed timescales.

People we spoke with told us that they had not had any reason to raise concerns. People who spoke on behalf of people who used the service told us that they did not have confidence in the management or the provider to raise concerns or complaints to them. One person we spoke with told us, "I am sick of raising the same concerns to her (the registered manager). All you get is that she has told people not to do it again and that she doesn't know what else she can do about it." Another person said, "I am not worried about raising concerns but I know that nothing will be done. They (management) never come out of the office."

When we asked people if they would be comfortable approaching the provider people told us that whilst they would, they did not see the point as, "They are never in the home."

When we spoke with staff about raising concerns, we received mixed comments. Some staff told us that they were put off raising concerns as, "There is a massive blame culture in here", and "There is a lot of finger pointing". Other members of staff raised the same concerns but said that they would not let this stop them from raising concerns.

This meant that whilst the service had a complaints process we were unable to assess its effectiveness as people who used the service, others acting on their behalf and staff did not have confidence to use the process.

Inadequate

Is the service well-led?

Our findings

We looked at the incident and accident books retained by the home and compared them to incidents recorded within the 'daily records' of people's care records. We compared both of these records to the accident and incident log that was completed by the registered manager on a monthly basis.

We found that the three sets of records contained discrepancies in the number of accidents and incidents that were reported month on month from November 2015 to April 2016. This meant that by not consistently recording accident and incidents, records were therefore not accurate or complete and could not be used as a contemporaneous record of the events that had occurred within the home. In addition it was not possible for management to then identify any trends in accidents or incidents and take corrective action to ensure people received appropriate care and support.

We spoke with the registered manager about quality monitoring within the home. They told us that there were a number of monthly quality audits that were completed which covered various areas across the home, including administration, kitchen, maintenance, care planning and medication.

We reviewed each of these audits for the months of January, February and March 2016. We identified that the audit process was not effective. The audits acted as a checklist and we found instances where the same issues were being picked up month on month but no corrective action was being taken. For example, medication audits completed 28 January and 28 March 2016 both identified issues with inappropriate items being stored in the medicines fridge but no corrective action ensued to prevent this issue recurring. This was also the same finding in reference to overstocking of medicines again identified in the January and March audits.

Care plan audits were completed. These consisted of a checklist and comments box. Audits carried out in March 2016 identified gaps in the care plans and detailed the corrective actions that were required. During this inspection we found that these issues remained outstanding as the actions had not been assigned to anyone for completion and review.

This meant that the quality assurance process in place failed to demonstrate they drove improvement within the home. The process did identify issues but failed to demonstrate who was taking accountability for managing the required improvements.

The service did not have an effective system or process implemented, for the purpose of the continuous monitoring of the service and the quality of care that was being delivered. The system that was implemented failed to ensure that where corrective action was required, that this action was carried out and assessed. The system failed to identify the multiple breaches of regulation that had occurred, and had no actions pending to remedy these breaches and improve the service.

Throughout the course of this inspection we examined a variety of documentation and had numerous discussions with staff across the whole home. As part of this process we identified a number of incidents

which under the conditions of registration are required, by statute, to be notified to the Care Quality Commission, which had not been submitted. In terms of statutory notifications under the Care Quality Commission Registration Regulations 2009 – it can be a criminal offence for failure to make Statutory Notifications under Regulation 18, by the registered provider and registered manager, as registered persons. We had discussions with the registered manager around their understanding of what a notifiable incident was. During this discussion the registered manager failed to recognise that service user on service user incidents, police incidents, and allegations of abuse or neglect are all notifiable to the Commission. This meant that the service had failed ensure that the thresholds and requirement to notify were understood across the home.

Staff we spoke with told us that the service did not promote a culture that was open, honest and empowering. Confidentiality was a topic that came up in all discussions with staff. One member of staff said, "Nothing you say to management is confidential. It is like Chinese whispers in the school playground." Another member of staff said, "If you raise concerns about anything the whole home know who said what, it's not on."

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

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Service users did not receive appropriate care and treatment that met their needs or reflected their preferences. Care plans did not reflect the care and treatment needs of service users, this was because the service failed to carry out appropriate assessments to capture the needs and preferences of individuals. Regulation 9 (1)(a)(b)(c) and (3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued a notice of decision to cancel the registration of the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The service failed to ensure that people who used the service, were treat with dignity and respect at all times whilst receiving care and treatment. Regulation 10 (1)(2)(a)(b)(c) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued a notice of decision to cancel the registration of the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 11 HSCA RA Regulations 2014 Need for

personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	consent The service failed to ensure that consent was obtained from all people using the service, and those lawfully acting on their behalf, before and during the delivery of care and treatment. Where people lacked capacity to give their consent the service failed to ensure that they acted in accordance with the principles of the Mental Capacity Act 2005. Regulation 11 (1)(2)(3)(4)(5) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued a notice of decision to cancel the registration of the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service failed to ensure that people who used the service were protected against the risks associated with receiving unsafe care and treatment to prevent avoidable harm or risk of harm from occurring. The service failed to assess the risks to people's health and safety during any care and / or treatment. Medication was not managed safely or appropriately administered to ensure people were safe. Regulation 12 (1)(2) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued a notice of decision to impose a condition to restrict admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service failed to protect people who used the service from abuse or improper treatment whilst receiving care and treatment. The service did not have robust processes or procedures in place to safeguard people for the risk of abuse. Where abuse was discovered or suspected, the service failed to take appropriate action, without delay, to investigate and refer the incident to the

	appropriate body. Regulation 13 (1-7) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued a notice of decision to cancel the registration of the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The service failed to ensure that people who used the service received adequate nutrition and hydration to sustain life and good health and reduce the risks of malnutrition and dehydration while they receive care and treatment. This was because they failed to assess the nutritional and hydration needs of people, and failed to ensure that appropriate support was offered to meet these assessed needs. Regulation 14 (1-5) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued a notice of decision to cancel the registration of the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The service failed to implement and carry out effective governance, including assurance and auditing systems or processes. They service was not assessing, monitoring or driving improvement in the quality and safety of the services it provides, including the quality of the experience for people using the service. Regulation 17 (1-3) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued a notice of decision to cancel the registration of the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The service failed to implement and carry on robust recruitment procedures, including

Treatment of disease, disorder or injury	undertaking any relevant checks. They did not have a satisfactory procedure for the on going monitoring of staff to make sure they remain able to meet the requirements of their role. Regulation 19 (1-6) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

We issued a notice of decision to cancel the registration of the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers
Treatment of disease, disorder or injury	People who used the service did not have their needs met because the regulated activities are managed by an inappropriate person. This is because the person failed to properly perform tasks that are intrinsic to their role. They did not demonstrate the necessary competencies and skills to manage the regulated activities. Regulation 7 (1-3) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Notice of Proposal