Discovery Care Limited

Fourwinds Residential Care Home

Inspection report

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15 March 2017

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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

This inspection was carried out on 14 and 15 March 2017 and was unannounced.

Fourwinds Residential Care Home provides accommodation and personal care for up to 35 older people and people living with dementia. The service is a large converted property. Accommodation is arranged over two floors and a lift is available to assist people to get to the upper floor. The service has 31 single bedrooms and two double bedrooms that people could choose to share. There were 19 people living at the service at the time of our inspection.

At the last inspection in July 2016, we found the service was in breach of seven regulations and required the provider to make improvements. The service was rated Inadequate and placed in special measures. The provider sent us information about actions they planned to take to make improvements. At this inspection we found that the provider had not made the necessary improvements. We found continued and new breaches of the Regulations.

A manager was at the service each day. A registered manager had not been leading the service since May 2015. Following our last inspection the provider told us the manager would apply to be registered by January 2017. An application received had been rejected as it had not been completed correctly. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the care and has the legal responsibility for meeting the requirements of the law. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider and manager did not have oversight of the service and had not taken action since our last inspection to support staff to provide a good service. The manager began working at the service in August 2016 and had not been supported to develop the skills, competence and knowledge needed to fulfil the role. Checks on the quality of service continued to be ineffective and the shortfalls in the service we found at this inspection had not been identified.

At our last two inspections we required the provider to take action to make improvements to staffing levels. They had not done this. The assessments of people's needs used to decide how many staff were required on each shift had not been completed correctly. People told us they had to wait for the support they needed and were lonely and bored during the day.

Staff had not completed the training they needed to provide safe and effective care to people. They did not regularly meet with the manager to discuss their role and practice. Despite this, staff felt supported by the manager and were confident to raise concerns with her. Staff knew the signs of possible abuse and were confident to raise concerns they had with the manager. They were still not confident to raise any concerns with the provider as they felt they would not take any action.

People's relatives told us that concerns and complaints they had made about the service had not been resolved to their satisfaction. Complaints were not recorded and action had not been taken to use them to improve the service.

At our two previous inspections we told the provider to improve the way risks to people were managed. The provider had taken action to reduce fire risks. However, they had not taken action to manage other risks, including the risks of people losing weight and risks associated with the building. Detailed guidance was not available to staff about how to mitigate risks and people continued to be a risk. An analysis of accidents had not been used to identify any changes in people needs and plan care to reduce risks to them.

People received the medicines they needed to keep them safe and well. Medicines were stored safely however, they were not always recorded accurately to keep people as safe as possible.

Detailed assessments of people's needs had not been completed to identify their needs and plan their care. People were not involved, when possible, in planning their own care. Guidance had not been provided to staff about how to meet one person's needs. Guidance about other people was vague and contradictory. People were supported to have health checks such as eye tests.

Although people and their relatives told us that staff were caring, people were not always treated with respect. Staff did not listen and respond to people's requests, including requests for drinks. People told us they would like more to do because they were bored and lonely at times. An activities person spent time with some people. Other people were not supported to take part in any social activities, including having a chat with staff.

Meal times continued to be too close together and people told us they were hungry at times. Food was not consistently prepared to meet people's needs and preferences. People who chose to eat in their bedrooms were not supported to do this comfortably.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Applications had not been made to the supervisory body for a DoLS authorisation when people who lacked capacity to consent were restricted.

Staff did not follow the principles of the Mental Capacity Act 2005 (MCA) and people were not supported to make decisions. Assessments of people's ability to make decisions had not been completed and guidance had not been provided to staff about how to support people.

People, their relatives, staff and stakeholders had not been asked for their view of the service to support the provider to make improvements. The provider had not made sure the manager and staff understood their visions and values for the quality of the service provided.

Records about the care people received continued to be inaccurate. Information was not available to staff and health care professionals to help them identify any changes in people's needs. Action had not been taken to keep people's personal information safe and information was still stored in communal records which were accessible to other people and people not involved in their care. The provider was still not displaying their last inspection rating at the service and on their website, as required. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR.

Action had been taken to improve staff recruitment procedures. All the required checks had been completed, including obtaining a full employment history. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

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.

Risks to people had not been identified and action had not been taken to reduce them.

People were not always protected from the risks of unsafe medicines management.

The provider had not taken action to make sure there were enough staff to meet people's needs.

Staff knew how to keep people safe if they were at risk of abuse.

Checks were completed on staff to make sure they were honest, trustworthy and reliable before they worked alone with people.

Is the service effective?

Inadequate

The service was not effective.

Staff did not have the opportunity to meet regularly with the manager to discuss their role, practice or any concerns they had. Staff had not completed the training they needed to meet people's needs.

The times of meals had not been reviewed to make sure people were offered food regularly. Food was not always prepared to meet people's needs.

Staff did not follow the principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

People were supported to see health care professionals when they needed to, have health checks and to attend healthcare appointments.

Is the service caring?

Requires Improvement

The service was not caring.

People were not always treated with respect.

Staff did not have detailed information about people's likes, dislikes and preferences; or their life before they began to use the service. This would help staff get to know people and how they preferred their care provided.

People said that staff were caring to them. People were given privacy.

Is the service responsive?

Inadequate

The service was not responsive.

Assessments of people's needs had not been completed. Detailed guidance had not been provided to staff about how to meet each person's needs.

People told us they wanted the opportunity to take part in more activities at the service.

People's complaints had not been resolved to their satisfaction.

Is the service well-led?

Inadequate

The service was not well-led.

There had been no registered manager for nearly two years. The new manager had not applied to be registered with the Care Quality Commission.

The provider had not sent us the Provider Information Return we requested.

The performance rating was not displayed at the service, as required.

Checks completed on the quality of the service were not effective.

The views of people, their relatives, staff and other stakeholders of their experiences of the service had not been used to improve the quality of the service.

Records about the care people received were not consistently accurate and there was a risk that action would not be taken to provide the care people needed.

Fourwinds Residential 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 on 14 and 15 March 2017 and was unannounced. The inspection team consisted of two inspectors and an Expert by 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.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

We reviewed notifications we had received from the service. Notifications are information we receive from the service when significant events happen, like a serious injury. We spoke to a clinical nurse specialist for older people who had given the manager guidance about how to improve areas of the service.

During our inspection we spoke with seven people living at the service, three visiting relatives, the manager, a visiting health care professional and staff. We visited some people's bedrooms, with their permission; we looked at care records and associated risk assessments for six people. We looked at management records including staff recruitment, training and support records, health and safety checks for the building, and staff meeting minutes. We looked at their medicines records and observed people receiving their medicines.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We last inspected Fourwinds Residential Care Home in July 2016 and rated the service Inadequate overall. We found that the provider was in breach of a number of regulations. We served two warning notices and told them to take action to make improvements.

Inadequate

Is the service safe?

Our findings

At our May 2015 and July 2016 inspections we found the provider had not deployed sufficient staff to keep people safe and meet their needs. This was a continued breach of regulation and we served a warning notice requiring the provider to take action by September 2016. At this inspection we found that the provider had not taken the required action to make sure people were supported by sufficient staff at all times.

People told us, "I wake up when I want to but I need help so I have to wait until they are not busy", "I have to wait a while for someone to respond when they are very busy", "There are not so many [staff] at night and I have to wait", "The girls do try to come quickly when the buzzer is pressed but most of the time I do have to wait a while" and "I have a flannel wash in the mornings, not very satisfactory but there's not the staff or the time for anything else".

We observed one person sliding off their chair and at risk of falling from the chair to the floor. The person's relative asked staff to assist the person to sit up. The person did not receive the help they needed for at least twenty minutes because staff said they were busy. They continued to be at risk of sliding off the chair.

Other people with complex care needs did not receive care from staff for long periods of time during the day when they needed it. Staff only interacted with people to provide basic care such as offering them a drink or meal. Some people were isolated or lonely. One person told us, "Sometimes I do not see anyone all day. Only when my food is brought in and even then they don't really have time to stop and chat so it does get a bit lonely". We observed that staff only visited the person in their bedroom when they took the person a meal or a drink. The person's care plan stated, 'I am a friendly and sociable [person] but I do prefer to remain in my room either doing my puzzle books or watching the sport on television. I love to spend time chatting with staff in my room during the day'. The person was allocated 33 minutes of staff support during the day and had been assessed as not requiring any staff time to support them with activities. There was a risk that people may become anxious or depressed because of the lack interaction with other people.

The manager used a tool to decide how many staff were required to meet people's needs. This had not been completed correctly. For example, one person's assessment stated they needed 35 minutes support each day to meet their continence needs. We met the person and discussed their needs with the manager. They agreed the assessment was not correct and confirmed the person require two staff to support them and a minimum of 100 minutes of support each day. We found the person had not received the care they needed to remain clean and comfortable and was at risk of developing skin damage.

Action was not taken to make sure staff had the time they needed to support people. For example, maintenance staff set the emergency alarm bell off accidentally a number of times during our inspection. Care staff responded quickly to the emergency bell each time, leaving people they were supporting. This further reduced the time staff had to provide the support people needed and people wither had to wait for their support or received very little interaction from staff. The manager did not take action to stop this from happening.

The provider had failed to deploy sufficient numbers of staff to make sure that people's care needs could be met. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our May 2015 and July 2016 inspections we found that the provider had failed to consistently assess the risks to people and take action to manage risks. This was a continued breach of regulation and we served a warning notice requiring the provider to take action by September 2016. At this inspection we found that the provider had not taken action to keep people safe.

Some people and their relatives told us they felt safe at the service, others told us they did not. One person told us, "I feel as safe as houses". Another person's relative told us, they visited regularly and "I dread to think what would happen if I didn't".

Risks to peoples' skin health, such as the risk of development of pressure ulcers, had not been assessed. One person preferred to remain in bed for their comfort and required support from staff to change their position. This increased their risk of developing pressure ulcers. Their risk of developing pressure ulcers had not been assessed. Guidance about how to support the person was out of date and had not been amended as the person's needs changed. The person was not assisted to change their position regularly and this increased their risk of developing pressure ulcers.

Previously we found pressure relieving equipment was available to people who needed it, but was not always used correctly. Action had not been taken to make sure people's equipment was used correctly and they continued to be a risk of developing skin damage. One person's pressure mattress appeared to be too soft to offer them the maximum benefit from using it. The manager agreed and told inspectors they would look into it. They did not take this action during the inspection. Following the inspection we told a clinical nurse specialist for older people from the local clinical commissioning group about our concerns.

Staff had not obtained guidance about how to correctly set pressure relieving equipment if they did not know the person's weight. We asked the manager how they knew that people's equipment was set correctly. They told us the person who delivered the equipment had set it up and they had assumed that it was set correctly. Guidance had not been provided to staff about the safe and effective use of people's pressure relieving equipment so they received the maximum benefit from it. Staff told us they person did not have any skin damage.

Guidance had not been provided to staff following our last inspection about how to move people safely. The manager told us one person required a hoist to help them move. We asked the manager what sling was used to move the person. They told us, "The smallest one we have. It's down here somewhere (on the ground floor)". The person was in their bedroom on the first floor. An assessment of the person's needs had not been completed and guidance had not been provided to staff about how to move them safely. We would expect a competent member of staff to assess each person's moving and handling needs and provide detailed guidance to staff about how to move them safely, including the equipment to be used.

Accidents were recorded. The manager assessed these looking at the times to identify trends but did not look at patterns for individuals to reduce risks to them. One person had repeatedly fallen at night. The manager had instructed staff 'To maintain regular checks throughout the night. Not to be left alone whilst mobilising. Consider zimmer frame. Further action had not been taken to support the person to remain as safe and independent as possible. Referrals to the relevant health professionals had not been considered and left the person at risk of falling again.

Our two previous inspections found there were not enough call bells in the lounge and visiting professionals had asked the provider to make sure people were able to call for assistance when they needed it. People still did not have access to call bells and were not able to call for support when they needed it. People relied on other people or visitors, including inspectors, to inform staff they needed support. There was not always a member of staff in the lounge to respond to people's needs.

Parts of the service continued to pose a risk to people. Risks associated with the balconies on the ground and first floor had not been assessed and action had not been taken to mitigate risks. One of the two wooden gates which led from a balcony, down a slope to the road had been locked with two padlocks. This gate was part of the emergency evacuation route. The keys to the padlocks were stored in the office some way from the gates. We asked the manager what action staff would take if they needed to evacuate people through the gate. The manager told us, "They will go to the office and get the keys if they can". A person sitting on the balcony at the time told us, "I'd jump over it". Satisfactory action had not been taken to identify and manage the risks associated with the balconies and gates.

One bedroom was being refurbished during our inspection. The manager told us the door to the bedroom should be kept locked. The door was not locked and the room containing power tools and other decorating equipment was accessible to people using the service. A door from the bedroom onto the first floor balcony was unlocked. The manager asked a staff member to lock the bedroom door but the staff member did not check if anyone was in the room before they locked it and locked an inspector in. The lock was faulty and they were unable to unlock the door for approximately ten minutes. Fortunately a person living at the service had not been locked in the room with the decorating equipment and the balcony risks.

We identified risks associated with the management of fire risks and evacuation at our last inspection. Following our inspection we informed the local Fire and Rescue Service about our concerns. They visited the service and required to provide to take action. The provider had purchased fire evacuation equipment to assist people evacuate from the first floor and a maintenance person had shown staff how to use it. Some staff told us they had not practiced using the equipment and would not be confident to use it to evacuate people. There was a risk that at least five people would not be evacuated safely from the first floor of the building. Other action had been taken to manage risks associated with fire.

People had not been protected from the risk of being scaled by hot water. We tested the water temperature from the hot tap at some people's bedroom sinks. We found the water was too hot to hold a hand under. 'Caution hot water' signs had been placed above sinks. The manager confirmed that people living with dementia at the service may not understand what these meant. Environmental checks had identified thermostatic valves were needed to reduce the water temperature to a safe level. These had not been fitted and other action had not been taken to reduce the risk of people being scalded. Following our inspection the provider told us they had taken action to reduce the water temperatures.

Areas of the service and equipment used by people, including people's bedrooms, the shower room, hoists and wheelchairs were not clean. One person's toiletries, including prescribed creams, toothpaste and tooth brushes were stored together in a plastic box. The box and the toothbrush were soiled with leaked creams. We asked the manager how staff had supported to person to brush their teeth, they told us, "I dread to think". Action had not been taken by staff to keep the person's personal care items clean and the manager did not know when the person had received support to brush their teeth.

The provider had failed to consistently assess the risks to people's health and safety and take action to manage risks. They had failed to do all that was reasonably practicable to mitigate the risks to people and ensure that the premises were safe and was used in a safe way. The registered person had failed to respond

to and manage risks associated with major incidents and emergency situations. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had taken action to make sure the electrical wiring at the service was safe following our last inspection and a valid safety certificate had been issued by a competent person.

At our July 2016 inspection we found people were not always protected from the risks of unsafe medicines management. At this inspection one person told us, "I do get my medicines but always late". Prescribed cream administration records showed that staff did not support people to apply their prescribed creams at regular times. One person's relative told us their relative had not been supported to apply their cream in the mornings as prescribed to reduce their pain when moving around.

Staff had taken action since the inspection to improve the way high risk medicines were managed. All high risk medicines were stored and recorded correctly. However, not all staff who had witnessed the administration of high risk medicines had completed medicines management training. There was a risk that untrained staff would not identify administration errors.

The provider's 'Medication - Management' policy had not been amended to provide clear guidance to staff about how to support people to manage their own medicines. Two people administered their own medicines. Risks that staff would not identify mistakes people made when taking their medicine continued. One person told us their GP had doubled the dose of one medicine for two months. Staff told us the GP had doubled the dose for one month. Guidance received from the GP had not been recorded so staff could support the person to take the right amount of medicine for the correct length of time.

Some people were prescribed medicines 'when required', such as pain relief or to help them relax when they were anxious. Guidance had not been provided to staff about the 'when required' medicines each person was prescribed, including when it should be offered, how people might tell staff they needed it, or the minimum time needed between doses. There was a risk that people would not receive their medicines when they needed them or would be given their medicines when they were not needed.

Records of people's medicines administration records (MARs) had improved; however, records used to monitor the administration of prescribed creams were not completed consistently. One person's relative told us they were concerned that their relative was not receiving the pain relieving benefits of their prescribed cream. The manager told us they did not know if people's creams had been applied as their GP had prescribed to keep their skin as healthy as possible. The records of creams being administered had not been checked and the shortfalls had not been identified.

The provider had failed to operate proper and safe medicines management processes in relation to the ordering, storage, disposal and recording of medicines. This was a breach continued of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were now stored securely and at the correct temperature. We observed people receiving their medicines and this was done in a safe way.

Staff knew how to recognise signs of possible abuse and how to report it. They knew about the different types of abuse. However most staff had not completed training on keeping people safe. Staff told us they were confident that any concerns they raised would be acted on by the manager. However, they were not confident to take their concerns to the provider as they felt they would not be dealt with properly. The manager had not completed safeguarding training since starting work at the service and was not fully aware

of their responsibilities and the local authority safeguarding processes.

People were not supported to manage their money when they wanted to. For example, one person was not given their money until they had requested it many times over several hours. The person became increasing angry until they were given the money they had requested.

Action had been taken since our last inspection to operate effective recruitment procedures to make sure staff were of good character and had the experience necessary for the work they performed. Recruitment checks had been completed to ensure staff were honest, trustworthy and reliable to work with people. These checks included two written references and a full employment history. Any gaps in people's employment history were discussed and recorded. Disclosure and Barring Service (DBS) criminal record checks had been completed before staff began working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services. Checks on the identity of staff had been completed.

Inadequate

Is the service effective?

Our findings

At our last inspection we found that the provider had failed to make sure staff received appropriate training, support and development. This was a continued breach of regulation and we served a warning notice requiring the provider to take action by September 2016. At this inspection we found that the provider had not taken the required action. The manager told us they did not know what training staff had completed. Checks on staff's competence to complete specific tasks, such as moving people and providing personal care had not been completed to make sure that they had the skills required to fulfil their role. A training plan had been put in place to cover basic skills, however, training in relation to high risk activities such as moving people had not been prioritised and was not planned to take place until July 2017.

Staff had not attended practical 'moving people' training since our last inspection and did not always use safe practices when supporting people to move. We observed two staff moving a person from an armchair to a wheelchair, using a handling belt. Staff did not put the brakes on the wheelchair. As the person walked backwards towards the wheelchair it moved away from them. The person appeared distressed during the transfer and their anxiety increased when they were not able to sit down. No guidance had been provided to staff about how to move the person safely.

Some staff told us they had completed training in relation to supporting people with dementia. However, staff did not use the skills they had learnt when supporting people. One person who was living with dementia was anxious about their clothing during our inspection and told us it did not belong to them. They took the clothing off so we alerted the manager to this. The manager began to speak to the person about their clothing. The person became increasing anxious and began shouting. The manager shouted back at them. The person became more anxious and shouted louder, the manager shouted louder in response. The manager did not speak calmly to the person or try to reassure them. The person was supported to change their clothing but continued to be worried about it.

The manager told us they had not met with staff on a one to one basis (supervision) since they began working at the service in August 2016. They told us, "I have had a chat but not done any actual supervision". Staff had not met with the previous manager and had not had the opportunity to discuss their practice or development needs. Staff attended daily handover meetings at shift change so they were up to date about everyone.

The provider had failed to make sure staff received appropriate support and supervision to enable them to carry out the duties they are required to perform. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they did not like the food at the service. Their comments included, "We have a choice of two meals at lunchtime but I can say it is all the same mush", "The vegetables are important so why can't they cook them properly, they are disgusting without fail", "We can ask for more dinner but why would we want to, it is not very good" and "We cannot decide what is on the menu and we do not get asked what we would like to go on it".

Some people chose to eat their meals in their bedrooms. Staff did not support people to eat safely or comfortably in their bedrooms. One person was struggling to eat in bed. They had not been supported to sit up as much as they could and staff had placed a tatty towel across their chest to protect their clothes. The person was embarrassed about spilling food and apologised to the inspectors, who reassured them. They were not monitored while they were eating and risks of them choking because of their position had not been assessed. We observed another person eating their meal from their lap with a newspaper to protect their legs from the heat of the plate and another balancing their meal on a low chair in front of them which was made their meal difficult to reach.

Action had not been taken to prepare meals to meet people's needs and preferences. One person's relative told us they had to stop their relative from eating food they were allergic to which staff had given them. The person's relative had told staff about their allergy when they first moved in and this information was included in their care plan. Information about the person's allergies had not been shared with kitchen staff. Risks of the person becoming unwell from eating foods they were allergic to continued. Another person had lost weight. The manager told us the person was offered food that had been fortified with extra calories. Kitchen staff told us they did not prepare fortified food for anyone. There was a risk that the person would continue to lose more weight as food had not been prepared to meet their needs.

At our last inspection people and their relatives told us that mealtimes were too close together during the day and there was a thirteen hour gap between supper and breakfast. The provider had not reviewed the meal times and acted on people's feedback. One person told us, "Sometimes I only have a sandwich at tea time and then I get a bit hungry later".

The provider had failed to ensure food was prepared to meet each person's needs and preferences. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's capacity to make day to day decisions had not been assessed and guidance had not been provided to staff about how to support people to make decisions. People had not been supported to make decisions, for example, at approximately 17:00pm one person became anxious and told the manager they had not had breakfast or lunch. The manager told them they had eaten breakfast and lunch. A staff member told the person, "You haven't had any tea because you won't tell me what you want. I told you to sit down and think about what you want for tea". The person responded, "But that's just it, I don't know what I want". The manager and staff member offered the person a variety of food choices. They spoke over each other and the person became increasingly confused. The staff member told them again to think about what they wanted and tell them. This appeared to increase the person's confusion and anxiety further. After several minutes

the staff member took the person to the kitchen to look at the choices on offer.

The person's ability to make decisions had been assessed by the mental health team and was available in their records. This information had not been used to plan the person's support, for example, by suggesting staff show the person a limited number of choices to support them to make a decision. Guidance had not been provided to staff about what decisions the person was able to make or the support they needed from staff. The manager and staff did not know how to support the person to make day to day decisions.

The manager told us that people were not able to make complex decisions about their care and treatment. When people were not able to make a decision, decisions were made in their best interests by people who knew them well, including staff and their relatives.

Some people were being prevented from leaving or were under constant supervision so a DoLS authorisation was needed to ensure this was lawful. The manager had not fulfilled their responsibilities under DoLS. Some people's DoLS authorisations had expired and a further DoLS application had not been made. The manager had not considered making applications to the local authority for standard DoLS authorisations to deprive other people who lacked capacity of their liberty. They did not know who had a DoLS authorisation in place, who was waiting for a DoLS assessment by their local authority and who's DoLS had expired. The registered person failed to ensure people were not being deprived of their liberty for the purpose of receiving care without lawful authority. The risk of people being deprived of their liberty unlawfully had not been assessed and mitigated.

People moved freely around the building without restrictions but were unable to leave without the support of staff. Staff did not support people to go out when they asked. One person heard staff discussing taking another person out for a walk and said "I want to go out". A staff member told them, "When they come back then maybe you can go out". The person was not supported to go out during our inspection. Another person, who did not have a DoLS authorisation, asked to go to the beach. The weather was sunny and warm and the person was looking at the sea from the lounge windows. Staff told the person they could not go to the beach on that day and could go, "In the summer", which was several months away. The person asked to go out several times after this but was not supported to go out.

People told us, "I feel trapped as I can't walk and cannot get out much as everyone is too busy" and "I can't get out as much as I would like as I have to be taken by someone and no one has the time". One person went out with the support of staff during our inspection.

The provider had failed to act in accordance with the Mental Capacity Act 2005. The provider had restricted people's liberty of movement. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care was planned to keep people healthy. One person told us, "The doctor comes to me in my room if I need to see one". People told us they saw the chiropodist and optician regularly. One person said, "I have just had my eyes checked and they are tested once a year".

A visiting health care professional told us that staff contacted people's doctors without delay if they had concerns about people's health. They told us that staff asked them for advice about other people when they visited. Two staff had completed diabetes training and were qualified to check people's blood sugar levels.

People were supported by staff or people who knew them well to attend health care appointments,

including outpatient appointments. This was to support them to tell their health care professional about their health and medicines and to make sure that any recommendations were acted on when they returned to the service. One person's relative told us, "My relative gets all the support they need and they keep me informed of any necessary changes they make".

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us staff were usually caring, their comments included: "The staff are kind, there is only one person who is abrupt with me, I think they don't have the time you see so it puts pressure on them", "The staff are all friendly and have a smile" and "The staff treat my relative like one of their own, I have no concerns about happiness with caring staff".

At our last inspection we found that staff did not always treat people with respect or talk to them in a respectful way. Action had not been taken to make sure staff treated people with respect, offer them choices and respond to their requests. One person's preadmission assessment described the person's continence products as 'nappies'. One person told us staff did not listen to their wishes and rushed them at times. They said, "I like to take my time, no rushing. They [staff] take me downstairs far too quickly, when I am not ready".

We observed people in the lounge in the morning. During the morning people requested specific drinks, such as milk or coffee, staff did not provide them with the drinks they wanted when they wanted them. People could only have squash during the morning and had to wait for the tea trolley before they could have tea or coffee.

Before our inspection a nurse who had offered support to the manager to improve the service told us that people's tea was made in a teapot with milk. They had advised that this prevented people making choices about their tea. We observed that tea continued to be made with milk in a communal tea pot and people were not able to add milk to their tea as they preferred. We told the manager about this, they replied "Are they [staff] still doing that, I told them to stop". Staff added milk to coffee and sugar or sweetener to drinks without asking people about their preferences.

The daily routine at the service was organised around tasks which needed to be completed and was not responsive to people's wishes and preferences. One person told us, "I had a hospital appointment last week but they made me wait for two hours in the hall because it was easier to be downstairs early to suit them". The person was cross about this.

Staff supported people to choose where they spent their time, some people preferred their own company and stayed in their bedrooms, other people spent time in the lounge. However, people who chose to stay in their bedrooms told us they felt lonely at times and staff did not spend time with them. People's comments included, "I always like a chat and a giggle but no one has time for me" and "Staff are not inclined to stay and make conversation". Our observations confirmed this.

The provider had failed to provide care to reflect people's preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that personal, confidential information about people and their needs was not kept consistently safe and secure. Some information about people continued to be stored in communal

records and not personal records, such as people's weight. There was a continued risk that people would have access to other people's personal information.

The provider had failed to maintain a secure record in respect of each service user's care and treatment provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information about people's life history, for example, about their past career, was still limited and no information was available about one person. This information helps staff get to know people and provide their care in the way they prefer. One person had served in the forces and enjoyed chatting to inspectors about what they had achieved. Action had not been taken since our last inspection to make sure staff had as much information about people as possible.

Action had not been taken since our last inspection to obtain and make available to staff detailed information about people's preferences, likes and dislikes. There was no information about one person who had recently moved into the service. Some people were able to chat to staff and tell them how they liked their care provided, most people were not. Staff continued to rely on information shared with them by other staff and their own observations and there was a consistent risk that people may not be supported in the way they preferred.

Guidance had not been provided to staff since our last inspection about how to share information with people, such as showing them items. Some people were living with dementia and found it difficult to understand what staff were telling them. Ways of supporting people to understand had not been considered, such as using pictures, signs or objects. There was a risk that information would not be provided to people in a way that they understood. We observed staff serving people's meals and drinks without telling them what was being served. People did not always know what was on their plate.

People appeared relaxed in each other's company and the company of staff. Most staff showed an interest in people and people responded to them. One staff member had a very friendly approach and chatted with people in a caring way. They sat and spoke with several people during the morning about their night's sleep and looked at a book with another person. They had a pleasant manner and knew people well.

People had privacy. Staff offered people assistance discreetly without being intrusive. They made sure that doors and curtains were closed and people were covered when they provided their personal care.

People who needed support were supported by their families, solicitor or their care manager. Information was available about how to refer people to advocacy services when they needed support. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

Inadequate

Is the service responsive?

Our findings

At our last inspection we found the provider had failed to consistently assess people's needs and plan their care with them. We required the provider take action. They told us that they would ensure people were fully involved in planning their care by October 2016.

Before people were offered a service, an assessment of their needs was completed with them and their relatives. We looked at the assessment for one person who had recently moved into the service. Information about what the person was able to do themselves and the support they required from staff had not been obtained to help staff decide if they could meet the person's needs. For example, the assessment described the person's personal care needs as 'washing, personal care, can clean own teeth' and their continence needs as 'just pads'.

Further assessments of people's needs had been completed when people began using the service; however these had not been used to plan people's care. A care plan, including guidance to staff about how to provide the care one person needed, had not been written. We asked the manager why a care plan had not been written. They told us that staff knew the person's needs as they had received a short term service from Fourwinds before they moved in permanently. We asked why the care plan for the person's short term service had not been reviewed and put in place and the manager told us they had not considered this. It was noted in the person's assessments that they had an 'unsteady gait' and 'Mobility can be unsteady, but always supervised'. It also noted that the person did not use mobility equipment recommended to support them to walk safely. We observed the person spent much of their time walking around the building unsupervised. They appeared to be confused about where they were and what was expected of them. There continued to be a risk that people would not receive consistent and effective care as staff did not have information about how they preferred their care provided.

One person told us, "I don't bother with my care plan I just make sure I get what I need when I need it". Another person's relative told us, "I keep an eye on [my relative's] care plan and it is not always adhered to, I have to constantly ask for things to be corrected". Staff told us they continued to rely on people telling them about the support they needed or on information from other staff. They did not refer to people's care plans for information about the care and support they needed. Many people were not able to tell staff about their needs. There was a continued risk these people would not receive the care they needed.

The manager told us they had reviewed and rewritten some people's care plans in the seven months they had worked at the service. We looked at the care plan for one person with complex needs. Some areas of their care plan had been rewritten and others had not. Information about the person's needs was contradictory. For example, their mobility care plan stated 'on permanent bed rest' while their physical health care plan stated they were 'chair bound most of the time (see mobility)'. The person's care plan had not been regularly reviewed and did not provide staff with detailed guidance about how to provide the person's care in the way they preferred.

Previously we found people's moving and handling care plans did not contain guidance for staff about how

to move people safely. Action had not been taken to provide staff with this information. One person's care plan stated, '[Person's name] has 2 carers at all times to assist with the use of a full body hoist' and 'is being turned on a regular basis by staff'. Information about the techniques and equipment to be used to move the person safely had not been recorded. There was a continued risk that people may not be moved safely.

Detailed guidance was available to staff about how to identify changes in people's diabetes needs, such as the normal blood sugar levels for the person and the action staff needed to take if they went above or below a specific level.

The provider had failed to consistently assess people's needs and plan their care with them, with a view to achieving peoples' preferences and ensuring their needs were met. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last inspection the provider had appointed an activities coordinator who was working at the service. However, several people told us they still had nothing to do during the day. Their comments included, "There's not much going on here, we do ask and they say they will organise things but they never bother. I think something goes on downstairs but nothing worth joining in with", "There is nothing to do at all even my book is too heavy to hold" and "All there is is the telly and that's not much cop either. Luckily, I am able to enjoy my crossword or I would be bored stiff".

We observed people again sitting in the lounge for several hours each day with a television playing. People told us they were not watching the television. People were not offered a choice of watching particular programmes or films. People had informed staff at the residents meeting that they could often not see the television because of reflections on the screen. People who wanted to go out were not supported to do this.

The provider had failed to ensure that people's care and treatment was designed to reflect their preferences and ensure their hobbies and interests were supported. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A process to receive and respond to complaints was in place. Information about how to make a complaint was available on request but action had not been taken since our last inspection to make sure people were aware of it and that it was meaningful to everyone, such as using large print or pictures.

People and their families had made complaints and raised concerns about the service. The complaints and the action taken to investigate and resolve them had not been recorded. People's relatives told us they were not confident that complaints they made were dealt with and used to improve the service. One person's relative told us, "I have raised numerous concerns and the only way to describe the proprietor's response is he gives 'alternative facts'. He now actively avoids me if he sees me and is most unapproachable".

One person's relative told us they had raised their concerns about no heating or hot water with the provider in October 2016. The provider had told them 'everything is under control'. The relative told us that they felt the situation was not under control and the provider's response was 'deliberately vague'. They said the problems with the boiler continued for several months and they were not informed of the action the provider was taking to resolve the situation.

The provider had failed to operate an effective and accessible system to identify, receive, record, handle and respond to complaints by service users and other people. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The manager had been working at the service since August 2016. They had previously been the deputy manager but had left in 2015. They had not managed a service before and had not been supported to develop the skills they needed for the role, including completing a recognised management qualification.

Staff told us they felt supported by the manager but some still did not feel valued or appreciated by the provider. People and their relatives told us, "The manager is very easy talk to and approachable but her hands are tied, she doesn't have ultimate control to make any decisions" and "I cannot pinpoint it but I do not feel that there is a good chain of command".

The previous manager had delegated lots of tasks to staff and this reduced the amount of time they were available to provide people's care. The new manager had taken back some of these responsibilities and completed care tasks such as administering medicines. This provided support to staff but took the manager away from their management responsibilities. The manager had not completed some tasks such as reviewing and writing care plans and providing staff with supervision.

Staff had not been held accountable for the service they provided and the manager did not know about the shortfalls in service that we found. Since our last inspection the provider had not put systems in place to support the manager and delegate some of the responsibility for managing the service, such as providing out of hours support to staff and completing administration tasks.

At our inspection in July 2016 we found the provider did not have a clear vision of the quality of service they required staff to provide and how this would be delivered. Action had not been taken to make sure that the staff and manager shared the provider's vision. Staff were not able to tell us the standards to which the service should be provided and each staff member provided care to their own standards. These were lower than the standards some people and their families expected.

Values including dignity and respect continued not to underpin the service provided to people each day. A copy of the provider's philosophy of care was displayed in the entrance hall. Staff did not know about the provider's philosophy and it did not underpin the care people received. For example, people had not been supported to 'determine the direction of their daily lives' and had not been 'involved in the planning and implementation of their care'.

Staff were not given feedback about their performance to develop their skills and the lack of staff meetings and one to one meetings continued. Care staff worked together as a team well as they could to provide care to people.

People, their families, staff and other stakeholders had not been asked for their views and opinions of the service, since our last inspection, to help the provider improve the service. A relatives meeting had been held at the request of people's relatives following the publication of our last inspection report. A copy of our report had not been made available to people and their relatives. People's relative's told us they had not

been informed of the action the provider planned to take to improve the service and their offers of support had not been taken up. People and their relatives had not been involved in developing and improving the service. People's comments included, "I would say not one of my suggestions were put in place" and "A family meeting only happened once. I wouldn't say anything was acted on".

A residents meeting was held during our inspection. Before the meeting people told us, "I don't think residents are ever asked for their views and if they were it would not be acted upon". At the meeting people commented that they liked the decorating which had been completed. They commented that they did not like the green beans and asked for banana sandwiches to be added to the teatime menu. Staff replied that people could not have banana sandwiches as they would go black. They had not considered making the sandwiches fresh as people ordered them.

The manager and provider had not taken action to hold regular staff meetings. The manager had held one meeting since they began working at the service in August 2016. This had not been attended by all staff and further meetings had not been planned. Staff had not been given other opportunities to share their views of the service.

The provider had not taken action to improve their oversight of the service. They had not completed checks on the service to make sure that it was of a good standard. The manager had completed checks however these had not identified the shortfalls in the service we found.

The manager and provider did not consistently monitor and challenge staff practice to make sure people received a good standard of care. The manager told us the checks they completed were not recorded, so the development of the service could not be monitored. Checks on the service people received at night had not been completed to make sure people were received the care they needed and staff were performing their duties safely.

The provider had failed to assess, monitor and improve the quality and safety of the service provided to people. They had failed to seek and act on feedback from relevant people, including service users, on the services provided to continually evaluate and improve the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accurate and contemporaneous records in respect of each person's care and support had not been kept. At our inspections of May 2015 and July 2016 we found that records were not always maintained accurately. At this inspection we found that action had not been taken to make sure records kept about people's care were accurate and complete. Records did not to contain all the information staff and visiting health care professionals needed to assess, review and plan people's care, such as what they had eaten and drunk and when prescribed creams had been applied. Inaccurate records continued to put people at risk of not receiving the care they needed.

The provider had failed to maintain an accurate, complete and contemporaneous record in respect of each person, including a record of the care provided to them and of decisions taken in relation to the care and treatment provided. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider has a condition on their registration requiring them to ensure that the service is managed by an individual who is registered as a manager. A registered manager had not been working at the service since May 2015. The previous manager had not applied to be registered by Care Quality Commission (CQC) and we required the provider to comply with the condition on their registration. They told us the new manager

would apply to be registered by January 2017. They had submitted an application in February 2017 but this was rejected as it had not completed correctly. A further application had not been received.

The provider had failed to comply with a condition we had applied to their registration requiring them to ensure that the service is managed by an individual who is registered as a manager. This is a continued breach of Section 33 of the Health and Social Care Act 2008.

Registered providers are required to display the most recent rating of their performance by the CQC conspicuously at the service and on any websites maintained for or by them. At our July 2016 inspection we found the provider had not displayed the most recent performance rating at the service or on their website. We required that they do this. They told us they would do this 'by end of October 2016'.

The provider had not taken the action they told us they would take. The 'Inadequate' performance rating from our July 2016 inspection was not on display at the service or on the provider's website. A copy of the inspection report had not been shared with people and their families and friends and was not available at the service, so they could see the quality of the service. There was a risk that people and their relatives were not aware of the shortfalls at the service and the performance rating.

The provider had failed to display the most recent rating of their performance by the Care Quality Commission at the service and on websites maintained for or by them. This is a continued breach of Regulation 20a 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	Section 33 HSCA Failure to comply with a condition The registered person had failed to comply with a condition we had applied to their registration requiring them to ensure that the service is managed by an individual who is registered as a manager.

The enforcement action we took:

We cancelled the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had failed to ensure food was prepared to meet each person's needs and preferences. The registered person had failed to consistently assess people's needs and plan their care with them, with a view to achieving peoples' preferences and ensuring their needs were met. The registered person had failed to ensured people's care and treatment was designed to reflect their preferences and ensure their hobbies and interests were supported.

The enforcement action we took:

We cancelled the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person had failed to act in accordance with the Mental Capacity Act 2005. The registered person had restricted people's liberty of movement.

The enforcement action we took:

We cancelled the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had failed to consistently assess the risks to people's health and safety and take action to manage risks. The registered person had failed to do all that was reasonably practicable to mitigate the risks to people and ensure that the premises were safe and was used in a safe way. The registered person had failed to respond to and manage risks associated with major incidents and emergency situations. The registered person had failed to operate proper and safe medicines management processes in relation to the ordering, storage, disposal and recording of medicines.

The enforcement action we took:

We cancelled the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person had failed to operate an effective and accessible system to identify, receiving, record, handle and respond to complaints by service users and other people.

The enforcement action we took:

We cancelled the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had failed to maintain securely record in respect of each service user's care and treatment provided. The registered person had failed to assess, monitor and improve the quality and safety of the service provided to people. They had failed to

	seek and act on feedback from relevant people, including service users, on the services provided to continually evaluate and improve the service. The registered person had failed to maintain an accurate, complete and contemporaneous record in respect of each person, including a record of the care provided to them and of decisions taken in relation to the care and treatment provided.

The enforcement action we took:

We cancelled the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The registered person had failed to display the most recent rating of their performance by the Care Quality Commission at the service and on websites maintained for or by them.

The enforcement action we took:

We cancelled the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had failed to deploy sufficient numbers of staff to make sure that people's care needs could be met. The registered person had failed to make sure staff received appropriate support and supervision to enable them to carry out the duties they are required to perform.

The enforcement action we took:

We cancelled the provider's registration for this location.