Windsor Care Limited

The Manor Care Home

Inspection report

Church Road
Old Windsor
Berkshire
SL4 2JW

Tel: 01753832920
Website: www.windsormanorcarehome.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Manor Care Home is a residential care home providing personal and nursing care to 60 people aged 65 and over at the time of the inspection. The service can support up to 65 people.

The service operates over three floors that provide a secure setting for people who are living with dementia and associated needs. Each floor is keypad secured, preventing people from walking independently within the service. Staff support people should they wish to move between the floors. Each bedroom has an en-suite, that the person is able to use, in addition to communal bathrooms. Dining facilities and lounges are available on each floor. People can access the large communal gardens through the ground floor. An elevator enables access to all floors for people who have mobility issues. The 'Sun lounge' offers sensory stimulation to people and is accessible on the first floor.

People's experience of using this service and what we found
The care and treatment of people was not always appropriate and did not always meet their specific needs. Care plans did not evidence that people were being involved to the maximum extent possible in their care or that their preferences were always being taken into consideration. We found that next of kin were making decisions for people without having the legal authority to do so, and without evidence of best interest meetings take place.

People were at risk of potential harm because the registered person had failed to ensure the proper and safe management of medicines.

People were at risk of potential harm because risks were not appropriately mitigated, or actions identified where a risk was prevalent. The service had removed call bells from peoples' rooms without giving consideration on how they would seek support should the need arise.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Systems to ensure compliance with legal obligations and the regulations were not effective. Audits although completed, did not assess, monitor and improve the quality and safety of the service provided. The lack of robust quality audits meant people were at risk of receiving poor quality care and, should a decline in standards occur, the systems would potentially not pick up issues effectively. The registered manager did not have a thorough overview of the service.

People had their healthcare needs identified and were able to access healthcare professionals such as the GP, optician when needed. The service worked well with other professionals to provide effective health care to people.

Activities were offered to people and their families to improve wellbeing. Staff engaged well with people focusing on prompting communication and reducing social isolation. Sufficient staff were deployed to support people.

Staff were compassionate and kind when speaking with and supporting people. We observed good examples of care being delivered to people, with staff taking their time when engaging and completing tasks.

People's nutritional and hydration needs were well met. Staff ensured people were well supported to eat and drink. Meals were nutritious and met people's specific health needs.

The environment was clean and appropriate for the service type. Signage could help improve people's experience when living with dementia. For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 07 June 2017).

Why we inspected
The inspection was prompted in part due to concerns received about unsafe medicine management, poor practice and support for people and insufficient staffing. A decision was made for us to inspect and examine these risks in depth, as part of the scheduled inspection.

We have found evidence that the provider needs to make improvements. Please see all sections of this full report to identify areas where improvement is required. You can see what action we have asked the provider to take at the end of this full report. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Manor Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to regulation 9 (person centred care), 11 (need for consent), 12 (safe care and treatment) and 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at this inspection. Care provided was not always person-centred; people did not always receive safe care and treatment and were not always protected from the risks of harm; staff and management did not have a comprehensive understanding of capacity and the MCA and effective systems were not in place to ensure the service met the required fundamental standards of care.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

The Manor Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was completed by two inspectors and a specialist advisor registered nurse over two days. The nurse's specialism was dementia care and medication management.

Service and service type
The Manor Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection-

We spoke with eight people who used the service and four relatives about their experience of the care provided. We spoke with 12 members of staff including the registered manager, clinical care manager, the chef, trainer, care staff and registered nurses. We used the Short Observational Framework for Inspection (SOFI) during the lunchtime service. The SOFI is a way of observing care to help us understand the experience of people who could not talk with us. In addition, we made observations throughout the day.

We reviewed a range of records. This included nine people's care records and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● The service had a comprehensive business continuity plan in place. This depicted what course of action staff needed to take in the eventuality of an emergency. For example, in the event of no gas, no electricity, a virus breakout. However, contact details were incorrect, containing details of three senior staff who no longer worked at the service. This was amended once brought to the attention of the registered manager.

● People had risks identified in their care files, however sufficient information was not always provided on how to manage the risk. For example, where a person at times of distress displayed challenging behaviour, staff were not provided with guidance on how to mitigate the risk and manage it should it occur.

● Similarly, we found that some measures that had been employed to manage complex behaviours, such as people walking, restricted others whilst managing the person's risk. This is explained in more detail within the effective section of this report.

● On day one of the inspection we found 11 occupied rooms of 16 checked had call bells that had been removed from people's bedrooms on one floor. We spoke with staff regarding this, seeking clarification on why the call bell had been removed, specifically as the care files did not evidence either the removal of the call bell, or how this risk was to be managed. Staff advised that a passive infra-red (PIR) sensor system had been set up that alerted staff to people's movement. However, upon further discussion staff acknowledged that the PIR system was not a replacement to the call bells. The latter were to be used by people to alert staff to a need. It was unclear how long people had been unable to access a call bell, and whether any incidents had occurred as a result of not having access to one. The call bells were reinstated immediately. In the absence of calls bells there was no system in place for people to be able to seek support from staff when they needed it.

Whilst no known harm had come to any person, by not ensuring risks were appropriately mitigated and by removing call bells, people were at potential risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People had an individualised personal emergency evacuation plan (PEEP). The PEEP is designed to inform staff on pertinent information related to a person's mobility, ability to follow instruction and formal diagnoses that may impact in an emergency evacuation process. These were well documented.

● The service had a comprehensive schedule of managing and reviewing the environment to ensure it was safe from risk. This included scheduled checks including emergency lighting, fire equipment, window checks, water temperature checks and emergency drills. In addition, risks related to each person's environment and equipment were continually assessed. We noted the service was transitioning from paper records to computerised records.

Using medicines safely

● People did not always have their medicines managed safely. We were alerted to two separate incidents in 2019, by the registered manager where controlled drugs had gone missing. The provider had failed to ensure secure systems of storage were operated to secure the medicine. However, during the inspection we found that CCTV cameras had been installed to manage this risk.

● Medicines Administration Records (MARs) demonstrated that people had received their medicines as prescribed and in line with their medicine plans. However, we found that medicines that had been discontinued still appeared on MARs. This presented the potential risk of staff re-ordering discontinued medicines and incorrectly administering when no longer required. This issue was resolved when identified during the inspection.

● We found in several people's MARs topical records, the topical cream name and dose were not the same as what was offered. People could potentially be applied incorrect medicines that were either too strong or not strong enough to resolve the skin condition. We spoke with the registered manager and clinical lead regarding this. Both were unaware of this. The medicine audit had failed to pick up on these errors. We noted that the issue was resolved during the inspection process, however did highlight concerns that this had been undetected.

Inadequate medicine management systems meant people were at potential risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were trained to administer medicines, with competency assessments completed frequently, including observations of practice, to ensure people were supported safely.

● Staff supported people to take their medicines in a respectful way. Staff ensured that people's dignity was maintained when medicines were administered. People were asked if they were ready for their medicines and were told what they were being given with sufficient time offered to take them.

● Where people had medicines as required (PRN), for example for pain. There were clear protocols in place to advise staff of their use, and when these needed to be administered.

Systems and processes to safeguard people from the risk of abuse

● People were kept safe by the implementation of systems and processes to protect them from the risk of abuse. People and their families reported they felt that staff looked after them and they were safe.

● Staff received training in safeguarding, that was refreshed to ensure it was compliant with local authority guidance. All reportable incidents of potential safeguarding were appropriately reported to the Care Quality Commission (CQC) and the local safeguarding team, with follow on updates provided.

● The service had visual guidance in staffing areas and offices on the procedure to follow should abuse be suspected.

● We spoke with staff, all of whom reported they knew the procedures to report concerns. They were able to describe various forms of abuse, as well as the protocol to follow. Staff stated they would "not hesitate" to blow the whistle should they have any concerns.

Staffing and recruitment

●This inspection was in part promoted due to concerns related to staffing levels. Concerns raised were that there were insufficient care staff and registered nurses present across the service. Over the course of the inspection we observed the service had sufficient staff deployed to each of the three floors to support people living at the service. Each floor consisted of a registered nurse and health care assistants. Staff deployment was dependent on people's needs. The greater support required, the more staff available.

● The provider operated a suitable recruitment system to ensure new staff had the right skills and attributes to work with people. Most of the required pre-employment checks were in place, within the files reviewed. However, some files had incomplete information. We sought confirmation from the registered manager that all checks were meeting the legislation requirements following the inspection. We were reassured that all outstanding information had been obtained. The manager told us that all future staff files would be checked against legislation requirements.
● All new staff members were required to complete a comprehensive induction, which included the provider's mandatory and specialist training, in addition to shadow shifts. Where staff were new to care they were required to complete the care certificate. This is a set of 15 standards that ensure care staff have the required knowledge, skills and behaviours when working in a care setting.

Preventing and controlling infection
● The home was very clean. There were no malodours in the bathrooms or the home generally, and the home was well-kept and maintained.
● Staff training records indicated staff were trained in the prevention and control of infections.
● Personal protective equipment was available for staff, such as disposable gloves and aprons to prevent the spread of infection. Colour coded mops and cleaning products were used to prevent the possibility of cross contamination.
● The kitchens had been rated 4 out of 5 (good) from the FSA (Food Standards Agency). The FSA primary role is to ensure that services that serve or sell food, do so in line with hygiene standards. The rating of 'good' therefore illustrates the service was clean.
● The service completed frequent audits to ensure they maintained a high standard of cleanliness within the home. The housekeeper advised this was to ensure appropriate measures were in place to prevent contamination and the spread of infection.
● There was a concern identified by the use of one hoist sling by multiple people. Staff were unable to identify the frequency of when and who would ensure the sling was cleaned. It was determined this was washed once a week, however it remained unclear if this was wiped down after each use. The registered manager acknowledged the potential infection control risk and advised slings would be purchased for each person where required.

Learning lessons when things go wrong
● Electronic and paper records were kept of all incidents and accidents, that were assessed at senior management level.
● The registered manager and management team took the necessary action to implement the required learning identified from accidents and near misses.
● This information was used to note if any trends were present. Information was then disseminated to care staff, to use as learning.

Requires Improvement

Is the service effective?

Our findings

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

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

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.
In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

- Whilst DoLS applications had been made appropriately as required, we were not assured the service had a comprehensive understanding of the principles of the MCA.
- Whilst staff had received training in MCA, they were unable to fully explain the principles of the Act, and how to put this into action. We spoke with staff about their understanding of the MCA. We were told this was about "giving the person choice... for example, what they eat or drink…" however, staff were unable to relay or understand fluctuating capacity, being time and situation specific.
- We found that next of kin and relatives who had no legal right were given information or enabled to make decisions on behalf of people residing at the service. In one case, one relative decided what food the person should eat daily, whom they should meet (all visitors were to be reported), as well declined dental treatment, as they felt the person's health was deteriorating and treatment would not be beneficial. The relative had no legal right to make any of these decisions. The service had failed to complete best interest decisions on any of the issues to illustrate why these decisions had been made.
- Similarly, the registered manager told us of one example, where two people, both of whom had capacity had entered a consensual relationship. The service discussed with both prospective families the relationship without prior agreement from the people, as it was believed the families had a right to know. The relationship did not progress. The service had not maintained the people's confidentiality or respected their choice to make a decision.
- The service aimed to create an inclusive environment for relatives. In doing so, people who resided at the service had, on occasions, their autonomy, capacity to make choice and confidence breached. Whilst the service was trying to include relatives, by failing to have a thorough understanding of the principles of the

MCA, people had their liberty and ability to make choice removed.
● We found that best interest decisions were not documented where staff, relatives and professionals made decisions on behalf of people. For example, 11 bedrooms had a red rope hung across the doorway, restricting entry and exit from the room. We sought clarification from staff on why this was in place. We eventually determined this was to manage another person's walking behaviour. The red rope acted as a deterrent for the one person to enter all other 11 people's rooms. We checked the 11 files to establish if the 11 people had agreed to the red rope being in place. We found only one file contained agreement from the person. The remaining ten files contained no mention of the rope, no evidence of consent nor a best interest decision agreeing to the use.
● Where people had mental capacity, they were not provided the key code to exit the building although staff assured us that they would allow a person to leave should they ask.

The service did not ensure that care and treatment was delivered in agreement with people or the relevant person(s). This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● The home had been well adapted to accommodate people's changing health needs. Ramps, hand rails, wide corridors and doorways enabled people to mobilise independently. However, seating was not offered within the corridors to enable people to mobilise and rest.
● Over half of the people residing at the service were living with dementia. However, no signage, points of interest, seating, or information to assist people around the building was offered.

We recommend the provider seek guidance on how to ensure the environment is dementia friendly.

● People were involved in decisions about the décor of their rooms, which met their personal and cultural needs and preferences. People brought furnishings from their last accommodation that allowed personalisation of their rooms and communal areas. We saw photos of people from holidays and activities located within all communal areas. This created a homely feel to the service. The first floor was beautifully decorated with paintings across the corridor walls. These depicted the town the home was located within.
● There was an accessible, enclosed garden which people appreciated and had access to. People were encouraged to spend time in the garden with family and friends.
● One room located on the first floor was exceptionally well designed to offer a sensory experience to people. The 'sun lounge', was laid with artificial grass, had sounds of nature playing, furnished with garden furniture and blew both hot and cold air. However, we did not see this room being utilised during either day of the inspection.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The service completed comprehensive pre-admission assessments on all potential new admissions. These focused-on people's health, care and medical needs, to establish if the service could meet the needs of the individual. People and their relatives were requested to complete "homework" sheets that detailed important information related to care and things important to the person.
● We were told by the registered manager that these documents informed the care plans. However, we found that information did not always translate into the care plans as required. For example, we saw evidence where people's religious denominations changed from what was recorded in the "homework" to the care plan. Extremities in changes were noted for people, for example from being Catholic at point of referral to Protestant at time of admission.
● The care files did not contain sufficient information on how the person wished to be supported. Details

were missed, which provided specifics to enable person centred care. Although the care files were reviewed, these issues were not picked up. This is looked at in more detail within well-led section of this report.
● The provider ensured staff received training to meet people's complex needs, including health related issues, that may not be covered within the provider's mandatory training. This meant staff were better equipped to deal with people's complex needs reducing the need to source external input. We saw evidence of exceptional training being delivered in oral care. Information had been correlated by a visiting dentist and hygienist who worked collaboratively with the trainer to develop the training. It was noted that documentation within care plans did not always support the training that was given and was not updated as required. However, conversations with staff identified knowledge of how to apply the principles of what was taught.
● Relatives and professionals told us the staff delivered care in accordance with people's needs and guidance within the care plans. We noted that most of the information correlated within the care plans was from relatives.
● We saw that some individual care documents contained conflicting information pertinent to people's needs. For example, one care plan referred to the person having top dentures, with another section of the care plan referring to both top and bottom and the third section suggesting the person had all their own teeth. This meant that any new staff working at the service may not have a full understanding of the person's specific needs.

Staff support: induction, training, skills and experience
● People were supported by a well-trained staff team that were able to put their training effectively into practice, although care records was not always reflective of this. The training matrix illustrated staff had been provided training in the provider's mandatory training and additional courses to help staff work with people.
● Staff reported they had received a thorough induction that provided them with the necessary skills and confidence to carry out their role effectively. A rolling training programme meant that staff were continually refreshed with new training and updated with changes in best practice. The service had a trainer who specifically focused on developing training around people's individual needs to ensure that the service was supportive.
● One staff member said, "The training is very good. The new trainer is very apt and responsive".
● Supervision records illustrated that staff did not receive supervision within a formal structure consistently. We saw some records that indicated some staff had not been offered one to one support from their line manager in over 12 months. Several of the staff we spoke with were unable to advise when they had last been supervised. We discussed this with the management team who advised that the lines of supervision were being amended to ensure staff were being supported adequately. We were provided with information on how this would be actioned moving forward. However, some staff reported they felt well supported by management and the providers.

Supporting people to eat and drink enough to maintain a balanced diet
● People reported that the food was, "rather excellent." We saw evidence of homemade foods offered to people during all mealtimes. A menu was designed specifically around people's preferences. Alternatives were offered if people did not wish to eat what was on offer.
● 'Diet notification update forms' were used to communicate changing nutritional needs between care staff and the chef.
● We saw evidence of nutritional supplements being offered where this was required.
● Whilst fluids were monitored, targets were not always set. This meant that staff were unable to establish if the amount drunk was sufficient. The registered manager advised that this would be immediately remedied.
● Peoples weight was monitored weekly with the Malnutrition Universal Screening Tool updated as required

to ensure people were appropriately looked after.

● The service kept people well hydrated. Drinks were offered throughout the day, in addition to jugs of juices left in people's rooms and communal areas.

● People were encouraged to eat healthy foods. Snacks and preferred foods were offered where people did not wish to eat the food from the menu.

● Drinks and snacks were offered throughout the day. People and their relatives commented on how the service ensured people were eating and drinking sufficiently.

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

● The service worked closely in partnership with the GPs practice, dietitians, Speech And Language Therapist (SALT), hospital specialist teams and specialist nurses to make sure care and treatment met people's specific needs. We saw positive evidence of professionals being consulted with and liaised with to ensure people's changing health needs were met promptly. However accurate records were not always maintained of discussions had with external professionals. We have looked at this in more detail within well-led.

● People were assisted to seek medical support as and when needed. We saw evidence of people being supported to seek specialist input as required. This included introducing specialist equipment to help people maintain independence, changes in diet, changes in footwear as well as changes in bedroom furnishings.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has changed to requires improvement. This meant people were not always supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- We observed staff treating and supporting people with respect and dignity. In one instance we observed a person needing support by hoist to move from a chair to their wheelchair. We observed two staff spend in excess of 10 minutes with the person gently encouraging them and waiting for them to be ready before using the hoist. They interacted with the person throughout the manoeuvre, ensuring they were comfortable and had their dignity preserved.
- People were supported well during mealtimes. We saw staff interacted well with people and ensured that they were offered a variety of the foods available on the plate. Where assistance was needed, people were asked what they would like to eat. Staff waited until the person was ready before offering another mouth-fall.
- We observed staff interaction with people, and were told, "I am well supported here. Staff are polite and nice."
- However, the service did need to complete work specifically around people's diverse needs and how they could best support this. We saw people's religious needs were not always met, due to inaccurate recording of people's faith, and this not being picked up in reviews. Whilst the service did observe religious practice, where people were of differing faiths, no evidence was presented of how the service had enabled them to practice their faith or ensure this remained an integral part of their life.

Supporting people to express their views and be involved in making decisions about their care

- Whilst written documentation did not always evidence that people were involved in decisions related to their care, the interaction observed illustrated people were given choice about day to day things. We saw people being offered choice in food, drink or whether they wished to join an activity. Where people declined, staff would gently encourage a little later.
- We spoke about the importance of evidencing and ensuring people were involved as much as possible in all issues pertaining to their care with the registered manager. We were assured that this would be visited, and all care documents would be reviewed.
- The service encouraged meetings with people and their relatives. This was used to gauge opinion on the service and how improvements could be made. Quality assurance surveys were sent out and results correlated to evidence what had been achieved by the service based on feedback.

Respecting and promoting people's privacy, dignity and independence

- The service worked closely with people and relatives to preserve people's dignity and privacy.
- We saw positive interaction with people that enabled them to retain their independence. People were

gently encouraged to complete tasks independently with staff remaining present to ensure they were safe.

● Staff were aware of people's needs and consistently responded to them in a compassionate manner. People were offered time to mobilise and staff picked up on non-spoken cues, responding appropriately to maintain people's dignity when they were noticeably becoming distressed.

● People's rights to privacy and dignity were supported and maintained. Community professionals said the service promoted and respected people's privacy and dignity. One professional added, "We have always witnessed positive interaction between residents and staff."

● People's records were maintained and stored confidentially. All personal records were kept locked away and not left in communal areas of the service. Records that were maintained in people's rooms were done so with people or relatives' consent.

● On day one of the inspection we found that staff files were not maintained securely. These contained information pertinent to supervisions and personal information. The files were stored on a bookshelf, in a room that had the door open and was accessible to all. We spoke with the registered manager regarding this, who assured us the door is usually locked.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People's care plans were not personalised. Care plans did not identify how people had chosen to be supported nor illustrate any control over their needs or preferences. For example, we noted that next of kin and relatives were making decisions on how people should be supported without having the legal authority to do so.

●We found that care plans failed to provide sufficient information on how support was to be delivered. For example, where people required repositioning, timescales were not provided within care plans to stipulate the frequency of repositioning. Some charts indicated inconsistency within the frequency of people being repositioned. For one person, according to the chart they had not been repositioned for 10hrs. However, other people's chart illustrated they were being repositioned every four to six hours.

● People we spoke with did not recall being involved in discussions on how they wished to be supported. On the contrary relatives reported they were consulted on a continuous basis on how people were supported.

● We found that the service did not meet people's equality and diversity needs. People's religion was not observed, and opportunities to practice faith or culture specific measures were not employed. People were not given the freedom to make decisions related to relationships without discussions being had with relatives.

● The service, although aimed to work towards achieving good outcomes for people, did not seek information directly from people whom they were supporting. As a result, important information such as likes and dislikes were missing from people's care plans.

This is a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to meet people's individual preferences when supporting them.

Improving care quality in response to complaints or concerns

● The service had a complaints protocol in place that illustrated, what action was to be taken when a complainant raised concerns. This detailed, "[Provider] will not withdraw or reduce services because someone makes a complaint in good faith." The policy also states: "The complainant will feel free to complain without fear of reprisals…"

●However, people told us and we saw written evidence that people were not always able to raise concerns without fear of reprisal. We raised this with the registered manager who advised they would investigate this further.

We recommend the provider consider and seek guidance on how best to manage and deal with complaints. Where necessary training should be considered to assist staff in understanding their role in dealing with and

managing complaints.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● A communication care plan was in place for all people who lived at the service. This detailed their preference of communication. For example, verbal language, how to receive information and assistive measures to help aid communication.
● The service had ensured where possible people received information related to their care and support in a format that they could understand. This included written formats, the use of picture symbols, and bold fonts. ● Information related to activities and menus was presented using photographs or show plates where a person was unable to understand or process the spoken word.
● The communication care plan further explored how best to share information and explored how some people were able to read fluently, whilst others used gestures and facial expressions to communicate and express their needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● The service had a comprehensive activities schedule developed that focused on people's individual preferences and those that could be completed as a group.
● The activities co-ordinators worked in collaboration with external agencies to bring activities to the service where people were unable to access the community. For example, one person had an affiliation with horses. They were however unable to leave the service due to deteriorating health. The activities co-ordinators liaised with an external agency to bring a little pony into the service on an ongoing basis. This increased the person's communication and improved their outlook on life at the service.
● Similarly, another person who had moved to the service, was talented in arts. The activities co-ordinators successfully used technology to enable the person to paint again using numbers. The person told us they looked forward to their art sessions.
● We witnessed positive interaction over both days, where people and their relatives were offered and took part in meaningful activities. People were observed smiling, conversing with one another as well as external people who had come in to perform.
● The service promoted maintaining relationships with friends and relatives. People were encouraged to remain in touch with their friends. The service facilitated gatherings, including coffee mornings to enable reintegration and a feeling of acceptance and belonging for families of people living at the service. One relative told us, "They not only support [name] but us too."

End of life care and support
● At the time of the inspection the service was supporting five people on palliative care.
● We saw positive examples of end of life care plans within these people's files and of other people residing within the service.
● Staff had been trained in exploring and understanding end of life care, so to ensure this was as comfortable as possible for people and their relatives. We were provided examples of how relatives had been able to stay at the service with their loved ones as their end of time approached.
● We saw written evidence of relatives thanking staff for their "compassionate care towards [name] and me".
● Staff were requested to attend funeral services for people to allow them to have closure on the person's

death. This also enabled relatives to show staff appreciation for the work they had done with people as they had approached the end of their life.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff generally reported a positive culture of the home. The registered manager was available and visible throughout the service, completing daily walk arounds.
- Whilst the registered manager and staff team tried to ensure good outcomes for people, this was often at the detriment of people's choice and independence.
- Care plans were not individual to meet the person's specific needs. They failed to illustrate how people wished to be supported. For example, in one care plan it was identified that a person often walked in the corridor. However, the service failed to explore the purpose behind this behaviour. Rather than manage this, restrictions were placed on the person, with staff redirecting the person to their room if they "wandered out". By failing to pick this up repeatedly in the monthly reviews the service had inadvertently reinforced challenging behaviour, whereby the person became aggressive. This potentially impacted on the person's mental well-being.
- People were not empowered to celebrate their individual characteristics associated with faith, culture, ethnicity and sexuality. For some people this meant they were disempowered to continue with very important elements of their lifestyle, due to the service's failings.
- Poor understanding and practice of the Mental Capacity Act meant that people were inadvertently potentially prevented from doing things that they were able to make informed choice about. By empowering relatives or next of kin, when they legally did not have the authority to make decisions on behalf of individuals, the service placed restrictions on people.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager ensured that they fulfilled their legal duty in the event of something going wrong with a person. We saw evidence of written communication that had been sent to the person or their representative in this situation.
- Correspondence ensured transparency. The outcome of the investigation was clearly detailed with the person or their representative being given the opportunity to liaise with the registered manager about the outcome.
- However, it was noted that where complaints were made, whilst a letter was sent out highlighting the outcome of the investigation, copies of the actual investigation were not always documented. The letter also appeared to be identifying fault with the complainant with potential consequences identified should

complaints continue. This was not picked up by the registered manager as an area of concern, specifically as this was against the service policy of "free from reprisal".

Continuous learning and improving care

● The service did not have sufficient evidence of audits being completed that identified shortfalls and how these needed to be actioned. This meant that we were not assured that continuous learning and improvement of care would be achieved.

● We saw evidence of people's care not always being effective or responsive to their needs. This furthermore meant that people were not being supported in a way that was personalised to them and that was necessarily safe. Risks were not always mitigated, or actions identified should a risk occur.

● Where reviews of care plans were completed, these did not identify errors in documentation. For example, whether a person wore dentures or not. Similarly, errors or missing information pertinent to the person's individuality, for example religious faith and denomination went unnoticed, although reviews were taking place.

● However the service completed comprehensive trigger analysis of all incidents and accidents, including near misses. We noted action was identified to mitigate the risk of similar occurrences.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The registered manager had been in post for almost seven years at the service.

● We found that whilst a number of audits were completed at the service, these failed to pick up issues that we identified during the inspection. For example, the medicines audit did not determine that topical medicine cream names transcribed were incorrect or did not match what was applied.

● Similarly, we found that the issues pertaining to the red rope use, although had been active for a period of time, was not identified as a concern. Audits had not determined that the use was restrictive and there was a need for best interest decisions and risk assessments.

● Poor staff understanding of the different use of technology was evident in that no one had established call bells were not substitutes for PIR systems. This was not picked up as a possible risk when auditing care plans or the environmental risks.

● The registered manager was unaware of these shortcomings. Whilst audits were completed these were ineffective. Audits were delegated, without the registered manager retaining an overview of the outcomes. It was unclear what level of overview the provider had of the quality and safety of the service. Staff reported that the provider would visit the service frequently, however there was no evidence that they were involved in or retained oversight of the processes implemented to ensure compliance with the regulations.

The registered persons failed to consistently assess, monitor and improve the quality of the service in line with their legal obligations and regulations. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics and working in partnership with others

● We received positive feedback from professionals who visit the service. We were told that the management team worked well in maintaining and developing partnership in healthcare working.

● The local authority reported that the service engaged well, seeking clarity and support where issues were noted. However, where guidance was provided this was not always followed through by the service.

● The registered manager evidenced quality assurance surveys, seeking feedback from people, relatives and professionals. These illustrated that the service sought the opinion of external agencies to change the service. We saw positive examples of how things had been changed as a result of the feedback. For example,

changes in menu, activities as well as communal area décor.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider had not ensured that care and treatment was reflective of service users needs. Service users were not enabled to make decisions related to their care. Regulation 9 (1)(c)(3)(a)(b)(c)(d)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider had not ensured that service users were consulted in the development of their care. They had further failed to ensure they had met acted in accordance with the MCA (2004). Regulation 11(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not ensured that care and treatment was provided safely. Risks were not mitigated and medicines were not always managed safely. Potential infection control issues were not assessed. Regulation 12 (1)(2)(a)(b)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not ensured that systems and

processes were established or operated effectively to ensure compliance. Risks were not mitigated and records were not complete which placed service users at risk. Regulation 17(1)(2)(a)(b)(c)(3)(a)(b)