Runwood Homes Limited

Windmill House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Windmill House is a residential care home providing personal care and support to up to a maximum of 59 people. The service provides support to older people, including those living with dementia. At the time of our inspection there were 47 people using the service and 1 person in hospital.

People's experience of using this service and what we found
People continued not to be living in a visibly clean and well-maintained care environment and were not being protected from the risk of harm. This included people living with dementia still having access to unsecured risks such as razors and prescribed creams. People were not always supported with their personal care. We identified areas of concern relating to infection, prevention and control practices including a further deterioration in the rating of the service's food hygiene rating. Improvements to the guidance in place in people's care records, and ensuring this information was individualised and person-centred, was needed. This remained of particular concern in relation to the management and oversight of care for people living with diabetes.

A greater level of governance and oversight by the provider was required in the absence of a registered manager, to improve the standards of care provided, and to ensure actions were taken in response to incidents and accidents. Audits and checks needed to ensure the lived experience of people was being accurately captured, and changes made to care where required to uphold people's privacy, dignity and levels of independence.

Areas of improvement were identified in relation to the management of people's medicines, particularly where they received medicines covertly (concealed in food or fluids), and to ensure people's patch changing regimes were more accurate.

We found gaps in staff recruitment processes and support in place for new members of staff to ensure they were competent and had the required level of skills to safely support and meet people's assessed needs and risks. Improvements in relation to specialist training and competencies around supporting those people living with dementia remained an area needing to be addressed to improve people's overall quality of life.

People were mainly supported to have maximum choice and control of their lives and staff mainly supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

We received mixed feedback from people and their relatives about the standards of care and support provided.

Rating at last inspection and update
The last rating for this service was requires improvement with breaches of the regulations (published 07

December 2022).

Why we inspected
We undertook this focussed inspection to follow up on the warning notices served on 11 November 2023, relating to breaches of regulations 12 (safe care and treatment) and 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with the compliance dates for the warning notice of 09 December 2022 and 06 January 2023 respectively.

As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

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

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

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

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, checks of staff competency and suitability to work at the service, safeguarding people from risks of harm and abuse and governance and oversight of the service at this inspection.

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

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect. We will work with the local authority to monitor progress.

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

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Windmill House

Detailed findings

Background to this inspection

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

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

Inspection team
Day 1 consisted of 2 inspectors and 1 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).

Day 2 consisted of 2 inspectors and 1 specialist medicine inspector.

Service and service type
Windmill House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Windmill House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. We therefore liaised with the regional operations manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We reviewed other information held on our system. We used all this information to plan our inspection.

During the inspection
We spoke with thirteen members of staff including the regional operations manager, a manager from another service providing temporary cover in the absence of a registered manager, operations manager, 2 senior care staff and 3 care staff, an agency chef and kitchen assistant, 2 members of the laundry team and 1 member of the housekeeping team, as well as observing care and support provided in communal areas. We reviewed 5 people's care and support records and 22 people's medicine management records. We observed part of the medicine round on day 2. We spoke with 6 people and 4 people's relatives. We looked at 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 liaised with stakeholders after our inspection visits.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Using medicines safely

At our last inspection, we identified the provider was not ensuring risks relating to the health and welfare of people were fully assessed and safely managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, sufficient improvement had not been made, and the provider remained in breach of regulation 12.

- People continued not to be protected from harm. Risk items such as denture cleaning tablets, razors and personal care products were not stored securely. Keys were found on both days to be either in the cabinet locks or stored on top of the cabinets.
- People's basic care needs continued not being consistently met. We identified people with visibly unclean teeth and finger nails. Corresponding personal care records contained gaps. This did not demonstrate staff had provided support with to keep people's nails and teeth clean. We found people did not always have toothpaste in their bathrooms.
- Environmental risks remained poorly identified and assessed. People continued to have unsupervised access to kitchenette areas which placed them at risk of harm. Decisions had been made to remove kettles, and keypad operated hot water urns had been installed, however, these posed a scalding risk on the sides and top of the urns which had not been assessed.
- Risk management of people's diabetes care still needed improvement. Care plans were generic rather than personalised and continued to lack clear guidance for staff to know when to source medical advice.
- Responsibility for monitoring people's blood glucose levels was now the responsibility of the GP practice. However, we identified blood testing was not being completed by the GP in line with the frequencies stipulated in people's care records as agreed with the GP practice. The service was not monitoring this jointly with the GP practice to maintain people's welfare.
- The management of people's skin to prevent the development of pressure sores remained a risk. Gaps in repositioning records, in place to protect the condition of skin and reduce the likelihood of harm were identified.
- Items of equipment were visibly unclean or in need of repair. Equipment such as crash mats were found to be visibly unclean and damaged. We repeatedly found people's bedding to be soiled, and other soft furnishings in need of replacement. We found a toilet bowl with a hole in it, causing water to leak on the floor, this remained in use on our first day, but was locked off by day 2 of the inspection as a result of us bringing this to the service's attention.

● The provider was not learning from incidents, previous inspection feedback and enforcement action. There was a lack of action taken in response to the warning notices served to ensure people received consistent standards of care. The service improvement plan in place, and the level of progress the provider felt had been made was not reflective of findings at this inspection.
● People's medicines were not always managed safely. There was a lack of records to show when people prescribed medicated skin patches had the previous patches safely removed before a new patch was applied. This increased the risk of skin irritation or overdosing the amount of medicine given.
● Information about people's medicine sensitivities was not consistently recorded, this did not protect people from the risk of allergic reactions.
● Where people had medicines given to them concealed in food or drink (covertly), written information available for staff to refer to about giving people their medicines covertly was inconsistently recorded to ensure this was done safely.
● People's topical medicines such as creams were found to not be stored securely, increasing the risk of harm through ingestion. We also found gaps in the application of cream records.
● We identified gaps in records of medicine refrigerator temperatures. We could not be assured refrigerated medicines were being stored safely.

The provider continued not to be ensuring risks relating to the health and welfare of people were fully assessed and safely managed. This was a repeated breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding incidents were not being consistently reported. We identified incidents which met the threshold to be referred to the local authority safeguarding team and to CQC, which had not been reported, and were not recorded on the service's own safeguarding log.
● Poor standards of care were identified during this inspection. We asked the regional operations manager to address these concerns and provide assurances on action taken. Limited assurances were received, and we identified a lack of recording to demonstrate for example that they had spoken with staff to address risks and concerns in response to our feedback.
● Where people were experiencing multiple falls, these had not been reported to the local authority safeguarding team in line with local guidance in place for providers.
● We advised the regional operations manager to make retrospective safeguarding referrals in response to safeguarding concerns discussed during this inspection. This request was not acted on by the regional operations manager, we therefore made a second request to the regional operations manager to ensure this risk was addressed.

Safeguarding reporting processes were not consistently followed to protect people from risk of harm and abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People we spoke with repeatedly told us they felt safe living at the service, however, some people told us staff did not always treat them with kindness. One person stated, "When some help me to get dressed they can be a bit rough."

Staffing and recruitment
● Staff were not always recruited safely to the service. We identified poor completion of recruitment records including interview questions to determine if staff met the threshold to work at the service, or no record of an interview being completed.

● We identified gaps in the completion of staff supervision and probation reviews, as well as incomplete induction paperwork and competency checks. We could not be confident new staff were being monitored to determine their suitability to work safely within the care environment.
● Staff told us they were not receiving regular supervision due to a lack of a manager being in post.

Risks relating to recruitment, supervision and oversight of staff was identified as an area of concern. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Three people told us they felt more staff were required, particularly to support with accessing the toilet during meal times, and to respond to call bells. However, this was not our observations and findings on either day of the inspection.
● Prior to our inspection, we had received a number of whistleblowing concerns alleging a bullying culture within the staff team. However, the staff we spoke with as part of the inspection did not provide evidence to substantiate these concerns.

Preventing and controlling infection
● We continued not to be assured that the provider was promoting safety through the layout and hygiene practices of the premises. Areas of the service were found to be visibly unclean. This included people's bedding and pillows, curtains, cushions and crash mats.
● We found limescale present on taps and shower heads impacting on infection prevention and control standards.
● We found damaged surfaces, including broken chairs, chipped paintwork and areas of unsealed flooring impacting on the ability for staff to keep areas clean and free from infection.
● Since our last inspection, the service had been inspected twice by the environmental health department in relation to food hygiene standards. The latest rating from their inspection in May 2023, gave the service a 1-star rating – meaning 'Major improvement necessary.' This was a deterioration from the 2-star rating awarded in November 2022.

Visiting in care homes
● People were able to have regular visitors and access the local community and grounds of the service.

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

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

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Inadequate

Is the service well-led?

Our findings

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

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

At our last inspection, the provider had poor governance and oversight arrangements in place to maintain standards and drive improvement at the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, for all key lines of enquiry in well-led.

At this inspection, sufficient improvements had not been made, and the service remained in breach of regulation 17.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for 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, Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Governance and oversight of the service was poor. In the absence of a registered manager, there was a lack of oversight of the service by the provider. Their own audits and checks had not identified accidents and incidents were still not consistently being reported to the local authority and to CQC.
- Timely action was not taken in response to risks identified by the inspection. We offered opportunities for changes in practice and approach to be made in response to day 1 feedback, but risks such as unsecured personal care products, prescribed creams, visibly unclean bedding remained when we inspected on day 2.
- Audits and daily walk around checks remained ineffective. The checks in place were not findings the environmental risks and issues around care standards, such as people with unclean teeth and nails, that we found during the inspection. The audits and quality checks in place were therefore not effective in driving improvement.
- Care record audits required improvements. Issues we identified with the quality and details in care plans such as those for diabetes management, gaps in the completion of repositioning charts were not being identified and addressed to maintain standards of individual care and safety.
- Improvements to staff recruitment, induction and support were identified. The provider's own audits and quality checks had not identified gaps in staff files found during the inspection. This did not demonstrate required monitoring of staff competence and performance.
- Individual staff performance issues were not being formally addressed. Inspectors identified concerns during day 1 of the inspection, in relation to a lack of privacy and dignity afforded to 1 person during completion of their personal care. The regional operations manager assured inspectors this matter would be addressed but was unable to provide written evidence to demonstrate actions taken in response to our feedback.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

● The progress recorded in the service improvement plan was not an accurate reflection of findings from this inspection. The document was not being regularly reviewed and was last updated in February 2023. Where actions showed as completed, such as the updates to diabetes care plans, these remained in need of improvement. Risk items remained unsafely stored, in part due to the lack of a universal key, yet the plan does not acknowledge this, and just confirms checks are in place daily.

● There remained a lack of learning from guidance previously provided regarding notifications to CQC and the local authority in line with the provider's own regulatory responsibilities.

● People's meal experience needed to be more person-centred. Some staff spent time providing more meaningful interactions, but most continued to demonstrate a lack of understanding how to support people living with dementia. The regional operations manager acknowledged staff required further training in this area.

Working in partnership with others

● We encouraged the regional operations manager to give updates to us on the actions being taken in response to our feedback, but these were not received, and did not demonstrate commitment to the inspection process.

● Ongoing improvements continued to be required between the service and GP practice to ensure people received consistent standards of health care provision.

● We received feedback from 1 relative who told us improvements in communication were needed. They said, "I do have some reservations about (relative's) keyworker. I don't get any feedback and don't feel I have a rapport with them."

The provider continued to have poor governance and oversight arrangements in place to maintain standards and drive improvement at the service. This was a repeated breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Overall, relatives told us they would felt comfortable raising concerns or complaints with the care staff, or with a manager once a new one was in post. One relative told us, "It will be good when the recent managerial and staff changes are sorted out."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The care provider was not ensuring staff were receiving support particularly when new, with a lack of probationary checks, supervision and checks of competency to ensure staff were able to meet people's needs safely. Recruitment checks including the completion of interview records to ensure staff were suitable to work at the service needed to be improved. This was a breach of regulation 18 (1)

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The care provider maintaining people's safety, including in relation to the management and oversight of medicines, and the safety and cleanliness of the care environment. This was a breach of regulation 12 (1)

The enforcement action we took:

Conditions imposed on the provider's registration at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The care provider was not keeping people safe, by ensuring safeguarding concerns were being reported correctly. This was a breach of regulation 13 (1)

The enforcement action we took:

Conditions imposed on the provider's registration at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The care provider did not have good governance systems and processes in place to maintain and drive standards of care and safety at the service. This was a breach of regulation 17 (1)

The enforcement action we took:

Conditions imposed on the provider's registration at this location.