The Windmill Care Home

The Windmill Care Home

Inspection report

Main Road
Rollesby
Great Yarmouth
Norfolk
NR29 5ER

Tel: 01493740301

Date of inspection visit:
24 September 2018
25 September 2018

Date of publication:
19 November 2018

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

We inspected The Windmill care home on the 24 and 25 September 2018. The first day of the inspection was unannounced.

We last inspected the home in December 2017 where we found eight breaches to six of the regulations. At this inspection we found 13 breaches to 10 of the regulations. At both inspections some regulations were breached more than once. Some action had been taken to address previous concerns but we found six continuing breaches. The provider had taken enough steps to meet the regulations regarding the cleanliness of the home and upholding people's dignity. At this inspection we have also made two recommendations as to how areas of the regulations can be improved.

The Windmill 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 Windmill care home supports up to 29 people with residential care needs. At the time of the inspection there were 28 people living in the home. The home was set over two floors with communal areas to the ground floor. At the time of the inspection an extension was being built which had reduced the available space used by people in the home. People had access to a large dining room, a much smaller lounge and a marquee which had been erected in the garden to the rear of the home. The marquee was carpeted and heated and had ample seating for people who chose to use it.

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

In December 2017 we found the provider had not provided appropriate activities to people living with dementia. At this inspection there were no activities being delivered.

At the previous inspection we found people's care records did not identify their needs and preferences and were not regularly reviewed. This inspection found this area had considerably deteriorated. We found care plans were not reflective of people's current needs and some had not been reviewed for nearly 12 months.

The last inspection found lawful consent was not gained from those people living with dementia. Action had not been taken to ensure consent was acquired in line with the principles of the Mental Capacity Act 2005 when people lacked capacity to consent to their care and treatment.

In December 2017 we found evidence to show the provider was not assessing the risks to people's health and wellbeing. Where risks were identified action was not taken to reduce the risks and the records held did

not reflect the support provided. This was still the case during this inspection.

Good governance regulations require providers to regularly assess and monitor the service provided. This is done to ensure both the service is meeting the requirements of the people being supported and to ensure standards are kept. During December 2017 we found the systems ineffective as they had not picked up the concerns noted by the inspection team. During this inspection we found systems had not been used for two months and those that had been used prior to that remained ineffective.

Staffing had been a concern at the inspection in December 2017 and a breach was evidenced. The provider told us they had trialled additional staff through the night but had felt they were not needed. This inspection clearly showed a lack of available staff. Communal areas were left unsupported for long periods of time and people told us they had to wait for support. We saw people required support with their personal care needs long before it was offered.

During this inspection we found management and staff were not trained or equipped to confidently deliver the service expected. The manager often found themselves delivering frontline care. This meant the home was not adequately managed. Staff were delivering support which they were not competent to do. There was no evidence to show staff had been adequately trained, supervised or appraised on the service they delivered.

People were not supported to have maximum choice and control of their lives and staff did not appropriately assess people's needs to ensure they were supported in the least restrictive way possible; the policies and systems in the service did not support good practice.

Refurbishment works were being completed to the building. This had led to changes around the environment. Risk assessments were not available on the day of the inspection for the environment. After the inspection we were provided with risk assessments for some aspects of the building and will monitor this moving forward.

The provider supported older people many of whom were living with some form of dementia. Research continues to be undertaken to develop best practice and to share the impact different environments can have on people living with dementia. During this inspection we did not find any best practice guidance had been followed either in the development of the extension or within the main body of the home.

Throughout this inspection we found the records of the service delivered, to be poor. Daily records were task focused and did not identify when people were last bathed or had a shower. Care plans and risk assessments were not updated, to show when people's needs had changed, meaning staff did not have the information they needed to support people effectivity. Contemporaneous records were not kept of the support, care and treatment delivered to people as required.

Where people were at risk of malnutrition or dehydration we found information used to support people was not monitored to identify if there were ongoing and unmanaged risks to people. Some people continued to lose weight without appropriate support.

We looked at the personnel files for staff recruited at the home. Safe and equitable recruitment procedures had not been followed. Staff had changed roles without completion of a fair recruitment process. References were not always checked and when missing, appropriate risk assessment had not been completed.

Staff told us they felt supported by each other and the manager at the home and someone from visiting clergy told us the home had a great atmosphere. We did find the home was supported by staff who showed us they cared for people in the home. However, they did not have the information they needed to safely care for them.

People in the home told us they liked the staff but they were so busy. Staff were keen to develop and were patiently waiting for new staff to be recruited to enable them to better fulfil their roles.

The overall rating for this service is 'Inadequate' and the service is therefore 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 inspecting 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 act 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 if they do not improve

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.

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.

There was no evidence that staff had attended safeguarding training in the previous 12 months prior to the inspection. People were restricted without appropriate assessment.

There were not enough staff and staff in place were consistently undertaking the role of others. People were left unsupervised for long periods of time and care and support was not delivered in a timely way.

We saw risk assessments to support people were out of date and did not include all the information to reduce risks

Medicines were stored, managed and administered safely

The provider did not have a system developed to learn from incidents and concerns.

Is the service effective?

Inadequate

The service was not effective.

The provider had not introduced latest best practice guidance and policies and procedures were out of date.

Evidence of staff training was poor and only basic training had been delivered. Staff told us they felt supported but formal induction, regular supervision and annual appraisals were not undertaken. We were told staff are too busy delivering care.

Assessments for people's nutritional needs were out of date, action was not routinely taken as soon as needs increased.

The refurbishment and redevelopment of the home had not been safely managed. The home was not adapted to support people living with dementia.

The principles of the Mental Capacity Act 2005 were not followed but we did see basic consents from those who had capacity were gathered.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

People told us staff were caring and treated them with respect.

We saw some evidence of people and their families being involved in the development of care plans. However, people's preferences and needs were not reviewed with their involvement nor in a timely way.

Advocacy support had been provided to support three people.

We saw pleasant staff interactions but also some which were undignified. Specifically, by agency staff, at the lunch time service.

We heard staff giving people choices and asking permission prior to support and interventions.

Is the service responsive?

Inadequate

The service was not responsive.

Person centred care was not being delivered. The daily records and handovers were task orientated. Care plans were not developed to encourage independence and autonomy.

There were not any activities taking place and there had not been activity coordinator for over two months. A volunteer was due to start one day a week.

There was an available complaints procedure. We were told staff were proactive at dealing with people's concerns

End of Life Care was not developed. Plans of care had not been completed for people living in the home.

Is the service well-led?

Inadequate

The service was not well led

The home lacked a governance structure. There was not a clear understanding of roles and responsibilities from the provider to care staff. A service ethos, values base and culture was not developed.

The system for quality monitoring and audit was not effective. It had not developed since the last inspection and had not been

reviewed or evaluated to ascertain its effectiveness

Information of concern had not been shared with the Care Quality Commission as it should be.

We saw feedback had been gathered from people in the home but it had not been collated. We could see from the questionnaires we looked at responses were predominantly positive.

The Windmill 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 checked 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.

We inspected the home on 24 and 25 September 2018. The first day of the inspection was unannounced.

The home was inspected by an adult social care inspector, a bank inspector 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. The expert by experience supporting this inspection had experience of caring for someone living with dementia.

Prior to the inspection we reviewed all the information we held about the service including any notifications received and any information shared with us via our website 'share your experience' form. We looked at information shared with us from the Local Authority including the local safeguarding team. We contacted key people for feedback prior to the inspection and we used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to develop a plan for the inspection which we referred to during our time on site.

During the inspection we spoke with nine people who lived in the service and two visiting relatives. We spoke with 10 staff including the registered manager, administrator, directors of the company, senior carers, carers and maintenance team. We also spoke with domestic and catering staff and one visiting clergy.

We looked in nine people's full care plans and room files for five people. We looked at medicines records, accident and incident information and any complaints received. We looked at staff rotas and documentation staff used to help them deliver the service including the handover documents and daily records.

We looked at management information including the professional testing of equipment certificates, any audits completed and four staff recruitment files.

We looked around the home including the communal areas, kitchen, laundry and people's bedrooms. We looked in the marquee which had been erected as a temporary lounge. We did not look at the interior of the extension works as trades people were on site.

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 also observed interactions between staff and people living in the home throughout the day, both whilst giving support and during general interactions.

Inadequate

Is the service safe?

Our findings

At the last inspection in December 2017 we found concerns and the home was rated as 'Requires Improvement' for the home to be safe. Concerns included a lack of staff to meet people's needs, poor infection, prevention and control and a lack of effective risk assessment and risk management. At this inspection we found one of the concerns from the previous inspection had been addressed but the remainder had not. We have also found additional concerns which have reinforced the service provided at The Windmill was not safe. At this inspection we have rated the provider as 'inadequate' in this area.

Most people we spoke with told us they felt safe. However, concerns were raised in relation to the marquee (the marquee was being used as the temporary lounge during development works) both by family members and noted by the inspection team. One person told us, "Sometimes I do feel safe and sometimes I don't because I think I'm going to fall, I am frightened of falling." We were told, and we saw, the marquee was often left without staff presence and people had fallen without support available.

At the last inspection we found the provider in breach of Regulation 12 safe care and treatment as people's risk had not been appropriately assessed and then mitigated. At this inspection we found this had not improved. When we looked at the accident records we saw people had fallen in the marquee but there was not a plan to reduce this risk. Risk assessments used to support people were not updated following a fall. This did not ensure the risks were assessed or action taken to reduce them. We looked at the records for one person whose support needs had changed following a fall that resulted in a broken hip. They now required the support of two staff and a full hoist for transfers, because of their injury. We looked at this person's moving and handling risk assessment and it stated the person required the support of one staff and the use of a stand aid. This meant there was no up to date guidance from staff on how the person should currently be supported, and there was therefore a risk of inappropriate moving and handling of the person. Staff told us this person was predominantly supported in bed.

We saw one person's pressure ulcer assessment had not been reviewed since November 2017 where their skin was recorded to be 'dry'. This person had a grade four pressure ulcer at the time of the inspection. Risk assessments had not been updated and staff did not have the information they required to keep this person safe. We were told the district nurse team were monitoring and supporting this person but there were not any changes made to the person's file. Monitoring of the pressure ulcer was poor and there was a risk this person was not being appropriately supported. We found assessments were not updated when risks increased and where risks were identified risk management planning was not developed or effective. This left a risk of people not receiving the support they needed to stay safe. All the risk assessments and care plans we reviewed were out of date and did not hold the current information on how to keep people safe. This meant the provider did not have a guide as to people's needs and a plan on how to meet them. There was not any appropriate evidence the person was receiving the support they required.

The above evidence was a continued breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At the inspection in December 2017 we found the provider in breach of Regulation 18 as there were not enough staff to support people safely in the home. At this inspection we reviewed the arrangements for staffing and spoke with both staff and people in the home about this. Every staff member we spoke with from the registered manager to care staff told us there were not enough staff. At the time of the inspection a dependency tool was not used to determine the staffing needed to support people. People living in the home told us they had to wait for the support they needed. We were told this was worse through the night.

Some of the bed bases were wrapped in cling film. We raised this with the registered manager who in turn shared our concerns with the provider. We were told the bed bases were getting soaked in urine and having to be thrown away and the cling film was a way to protect the bed bases. This situation had not been appropriately managed. It was obvious from the fact bed bases were getting wet, through mattresses, that people were not receiving personal care frequently enough. The solution to the problem would be to provide more frequent personal care not put cling film on the bed bases. There was not enough staff to support people with their personal care needs in a timely and effective and dignified manner.

During our inspection we saw areas of the home left unsupported for long periods of time when there were people using them. This included the dining room and marquee (used as the lounge at the time of the inspection). We saw people waiting to be supported with their meals and some people who were not supported who would have benefited from it.

The registered manager had developed a handover document which included staff allocations to specific roles and to complete specific tasks. We saw this was not used effectively and many of the roles and tasks were not allocated. We asked staff about this and we were told, "There wasn't the time." We were told the morning drinks trolley had not been taken around for some time. We did not see it on the days of the inspection. People did not receive the support required or had to wait for support to be provided.

The above concerns constitute a continued breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at the safeguarding policy to keep people safe and saw it was dated 2012. When we looked at the detail it referred to Care Quality Commission methodology over eight years old. We asked to see records for staff training to ascertain when key training such as safeguarding was last delivered. We were told the information we were shown had not been updated and did not reflect the current training levels. We asked the registered manager to provide the up to date details of when staff had completed safeguarding training but it was not provided by the time of writing this report. Staff told us they could not remember when they last did safeguarding training. When staff don't have up to date training they may not be aware in changes in how to recognise or report potential abuse.

We saw restrictive practice was used in different circumstances in the home. This included the use of lap belts on wheelchairs, bedrails on beds and sensor mats to alert staff when people moved from their beds. Where restrictive practice is used and people do not have the capacity to consent to it, assessments are needed under the Mental Capacity Act 2005 to ensure the practice is the least restrictive and is used in the person's best interest. We looked at the care information for four people who lacked capacity and restrictive practice was used. There were not any assessments to determine if the practice used was the least restrictive. We did not see any assessments to determine if the practice was used in the person's best interest and we did not see any assessments identifying the risks of the practice and how to mitigate them. This meant that people were potentially being restricted unlawfully.

The home was being refurbished which had reduced the available space in the home. One person was not

supported out of bed. We were told it had become more difficult to support the person due to the available space. The provider had completed a DoLS application to restrict this person to their bed. An assessment of their capacity had not been completed and a best interest meeting had not taken place to ascertain if this was the least restrictive option. The application had not been authorised but the person was still restricted to their bed.

When restrictive practice is used and the principles of the Mental Capacity Act 2005 are not followed it is a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at three staff personnel files to review the information held on how they were recruited to their post. We found several of the required documents missing. This included one missing application form and all three interview records. We saw references were not certified or were missing. We also saw two staff members had changed roles and there was no evidence of formal recruitment to the new role.

All staff had received a suitable Disclosure and Barring Service (DBS) check but other checks to ensure they were competent and safe to complete their role were not included or completed. When recruiting staff to work in vulnerable settings there is clear guidance under schedule three of the Health and Social Care Act of what is required. The personnel files we looked at did not include this information. This meant the provider could not be certain staff were suitable for the role to which they were employed. There was not the required evidence to show the recruitment procedures followed by the provider were equitable and fair.

The provider was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed systems in place for learning from incidents and concerns and identifying action to reduce reoccurrence. We found the provider had not built into the governance framework a structure for this at the time of the inspection. We were told management meetings were to commence the following week. The agenda would include complaints, accidents, incidents, safeguarding concerns and any other issues.

The provider had completed the required professional testing of equipment including the lifting equipment and electric and gas installations. We found the fire equipment had also been suitably tested. However, we noted the provider was not completing weekly checks on emergency lighting. When we pointed this out we were assured this would begin moving forward.

People's files included plans to safely evacuate people in the event of emergency and the provider had developed contingency plans to continue delivering the service in the event of an emergency. However, we noted the provider had not completed any risk assessments for potential emergencies to reduce the risk of the inappropriate management of these events.

We recommend the provider ensures risk assessments are completed to reduce the risk of emergency situations such as fire or widespread infections.

At the previous inspection, the provider was found in breach of the Regulation in relation to infection prevention and control. We found steps had been taken to address this. An action plan had been developed and shared with staff and had been implemented. We saw cleaning schedules had been developed for the building and environment as well as individual cleaning schedules for items such as commodes and crash mats. The Local Authority infection control team had been into the home and worked with the registered manager to address concerns raised.

We noted that during the meal service people were not given opportunity to clean their hands prior to eating. Staff told us that those people that had been supported with personal care prior to mealtimes would have washed their hands then but this was not the case for everyone. We saw the hands of some people were dirty and could be an infection control concern. Staff told us there had been a shortage of wipes to clean people's hands. We spoke with the registered manager about this who assured us wipes were available for everyone's hands to be cleaned prior to mealtime service.

Staff told us they had been trained and tested in their competence for managing and safely administering medicines. We did not see evidence to corroborate this as the training matrix was out of date but we saw staff completing the role competently. We saw care plans were person centred including details of how each person was prescribed to take their medicines.

People told us staff ensured they took their medicines. One said, "They always stand there and watch me take my medicines." Another said, "They make sure I take my tablets on time and I have taken them before they leave." Care plans were updated to reflect when medicines were to be taken as required and we saw appropriate guidance of when these medicines were to be administered. There were suitable systems in place for the storage, recording, administering and disposing of medicines.

Inadequate

Is the service effective?

Our findings

At the last inspection in December 2017 we found concerns and rated the home 'Requires improvement' for the home to be effective. Concerns were primarily associated with a lack of understanding of the principles of the Mental Capacity Act 2005 At this inspection we found the concerns from the previous inspection had not been addressed. We have also found additional concerns which have reinforced the service provided at The Windmill was not effective. At this inspection we have rated the provider as 'inadequate' in this area.

At the last inspection in December 2017 the provider was found to be in breach of Regulation 11 as appropriate and formal consent had not been acquired from people relating to their care. At this inspection we saw staff asked people for their consent prior to supporting them in most occasions. We did see two staff supporting people with their food who were doing so without any dialogue. We looked at records for consent and found basic consent had been acquired from people. This included consent for photography and for the home to administer medication. However, this was not routinely the case when people lacked the capacity to give consent themselves.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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. The application 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.

When people could not consent, capacity assessments had not been completed for the decision required. We saw two capacity assessments which were confusing and included information about more than one distinct decision. One included a capacity assessment to agree a change to the person's medicines, their admission to hospital and more complex decisions which were not stated. The assessment determined the individual did not have capacity to make the decision as if just one decision was asked. There was no information or any pictorial or other communication tools used to support the person to make the decision. There was no decision recorded as to how the provider would support the person in the three scenarios. Capacity assessments in four of the files we looked at, all showed a lack of understanding on how they should be completed and what the next steps should be.

One assessment for going out in the community included the line 'the lap belt must be used as the person tries to get out of the wheelchair'. There was no capacity assessment completed as to the person understanding the risks of getting out of the wheelchair. There was no information to determine how this could be managed or if the lap belt was the least restrictive option or done in the person's best interest.

There was a consent form for the restrictive practice signed by the person's relative but no available information to show the relative had power of attorney and the authority to give the consent.

The provider returned a Provider Information Return (PIR) in September 2018. Within that return we received information about the DoLS and restrictions used at the home. The PIR stated 24 people were subject to authorisations of DoLS. This was not the case. The return stated that no one had a care plan for restrictive practice. This was not the case. Staff we spoke with were not sure who had an active DoLS and the registered manager did not have a list that was provided. We saw one DoLS application in a person's file for being restricted in bed but it was not authorised. The Commission had not received any notifications informing us of authorisation of DoLS.

We found the home had not applied the principles of the MCA. Capacity assessments were not completed and best interest decisions were not reached. Where people lacked capacity, there were not any steps taken to gain lawful consent. This meant that where people lacked capacity appropriate consent had not been acquired for the delivery of the care and support they received.

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

Staff all told us there was a lack of staff but all told us they felt supported and received good training. However, we were not able to see evidence this in the records of training we were shown. We read team meeting minutes from the last 12 months and found the tone of the meetings were aggressive. The minutes described a staff team who continued to not follow direction and disciplinary action was threatened. Items discussed remained on the agenda over the 12 months and key areas were not discussed such as safeguarding and complaints. Change was not supported and therefore was not taking place. Ongoing issues included the senior's inability to run their shift, paperwork not being completed accurately and allocations not being completed so people's needs were not being met. This included support to get people up and support people with their mobility. The last team meeting minutes we were shown were from a meeting in April 2018 and we were told by the registered manager there had not been one since. That team meeting identified concerns including, staff not cleaning up spillages, not cleaning commodes and using their mobile telephones whilst on shift.

We found supervisions were not regularly taking place and all the staff we spoke with where unsure what an appraisal was. There was not any evidence anyone had received an appraisal. Staff did not have the qualifications, skills and competence to fulfil their role and care for people effectively.

We were told by a senior carer that 12 people required the support of two staff for transfers, we saw people in the home who stayed in their wheelchairs for most of the day. We saw one person sat in a quieter lounge on their own all day and we did not see them moved to eat their lunch in a different environment or moved from their wheelchair. We did not see them receive support with their personal care. People were sat in the same position for up to five and potentially longer.

Staff were aware that people in the home had developed pressure ulcers because of not moving from one position to another and continued to not change people's positions for long periods of time.

District nursing teams had noted gaps in the training needs of staff at the home. This was specific to moving and handling and managing skin integrity. This training had not been delivered and it was clear during the day of the inspection that the lack of immobility of some people in the home increased the risk of pressure areas.

There was a risk that those people who already had pressure ulcers, condition could worsen and people who did not have pressure ulcers could develop them.

Staff were not suitably trained or supported to undertake their daily core jobs. When we asked the registered manager about how seniors supported staff during shifts we were told "They are too busy caring for residents." Care staff completed care roles without appropriate training and support.

The above constituted a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014

The provider was supporting older people many of whom were living with varying levels of dementia. The home and the environment was not adapted in any way to meet the needs of this group of people. The provider and registered manager were not aware of the guidance and Regulation in this area.

The home had not been redecorated for some time and was very dated. The current layout and decoration of the home did not meet the needs of the people living in the home. Carpets on the stairs and in some hallways, were highly decorated as were some wallcoverings. Research shows home furnishings, carpeting and walls should be plain and in contrasting colours to help people living with dementia easily identify objects and their surroundings.

The development of the new extension to the side of the property had not been well managed. There had not been a risk assessment completed of the impact on the people living in the home. A large marquee had been erected to the rear of the property and people were using this as their lounge area. There was free standing furniture and tall book cases which were not fixed. The floor was uneven in the marquee and these items were at risk of toppling over if people leaned on them. There were cables trailing on the floor and to get into the marquee people had to come from the main house down a ramp across concrete and over room dividers. We saw people completing this journey alone who were unsteady on their feet. The door to the marquee was sometimes locked and sometimes open restricting access to it for people in the home. We were told by the registered manager it was locked so people could not enter it without support and was opened after meals for people to go and sit there. This was not the case over the course of the inspection. On the second day the door was wide open each time we saw it and we could access the marquee as we wanted.

We found the provider had not adapted the building to support the people living within it. Risk had not been assessed or mitigated for the refurbishment and the provider had not taken the time to research the development and design of the new extension. This left a risk of the building being adapted and decorated in a way that may not meet the needs of the people being supported.

When providers fail to ensure the premises is suitable for the people being supported it is a breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People we spoke with told us they liked the food. One told us, "The breakfasts are really nice here. I have bacon and egg and porridge each morning. The lunches are very nice. I can't fault the food here."

Care plans for supporting people with their nutrition and hydration had not been reviewed for some time. One we looked at, dated December 2017 said it was to be reviewed in January 2018 but this had not happened and had not been reviewed at point of the inspection. Two care plans we looked at noted the people to have lost between 3 and 4 kgs in between their monthly weights. The procedure dictated these people should then be weighed weekly but this had not happened. Neither person had been weighed since

July 2018. One file had a nutrition assessment which stated the person should be weighed twice a month and this had not happened. This left a risk of people continually losing weight and their health being at risk.

We spoke with the kitchen staff and looked at the information they held on different people's needs. There was good information available but the chef was not sure if it was up to date as they did not use it. They took advice on people's diets from the staff. We were told one person could not eat food with lumps in and was on a soft diet. This person was given apple crumble and custard. We did not see an assessment to ascertain how this person's food should have been prepared but one staff member thought they were at risk of choking on lumpy food.

When the home had concerns around people's diet records were kept of what people had eaten or drunk. We looked at these records for one person and found they were not consistently kept. When the fluid intake for people was being monitored there was not a prompt for staff as to what the appropriate intake should be. There was no prompt to ascertain when concerns should be noted if someone was at risk of becoming dehydrated. One person's record showed them drinking 650mls of fluid on one day and 350mls the next. This did not raise an alert with staff. The following day an ambulance was called as the person was very sleepy and finding it difficult to wake. The paramedics administered glucose boosters. When we looked at this person's care plan we saw they were diabetic. When people are diabetic their bodies react differently to sugars and insulin and is a condition where the diet and fluid intake should be managed carefully. Records of the food eaten were also poorly recorded and showed little nutritional intake.

When providers do not take steps to support people with their nutrition and hydration there is a risk they may become unwell. When records used to support people are not used effectively this risk is not mitigated.

The lack of effective nutritional support provided evidenced a breach of regulation 14 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We were told by people that if they needed to see a doctor they could be put on the list for the GP who visited most weeks. One person told us, "I can see the doctor if I want to or if they think I need to. I also see the chiropodist every three months."

Records for appointments and visiting professionals were kept in the back of care plans but we saw these were not up to date. The registered manager had identified this in a team meeting and requested staff keep on top of these records. Referrals had been made but there was no follow up information as to whether the specialist support had been provided and if any changes were made to the provided care. This meant staff did not have a record if any changes to support were required. The provider assured us this would be addressed.

Requires Improvement

Is the service caring?

Our findings

At the last inspection in December 2017 we found concerns and the home was rated 'Requires Improvement' to be caring. This was evidenced by a previous breach in relation to how people's dignity was supported. At this inspection we found some improvements had been made but further improvements were required. We have found additional concerns which have reinforced the service provided at The Windmill requires improvement to be caring.

At the inspection in December 2017, the provider was found in breach of Regulation 10, dignity and respect. We found the staff at the home had predominantly taken positive steps to ensure people's dignity was upheld and they were respected when providing care and support. People we spoke with told us, "I can't fault the care here, it's good." Another told us, "I would say they are caring, they are lovely people, I think most of them are very caring."

We spoke with a visiting clergy who visited the home regularly and supported people at the end of their life. They told us they thought the home had a pleasant atmosphere and all the staff were doing their best.

People we spoke with told us staff used their first name which they liked and told us they felt listened to, but no one we spoke with told us they had seen their care plan or were involved in developing or reviewing it. One person told us, "My [relative] got me in here with social services. I have never seen my care plan or spoke to anyone about it." Another said, "Social services organised my move here, I haven't seen a care plan so have no idea what to expect."

We looked in nine people's care plans and only in one of them did we see any information around their preferences and choices around how they liked to spend their days. This meant staff did not have the information they required to ensure they were delivering support in the way people wanted it to be delivered

The home had a dementia care strategy to support how the preferences and needs of people living with dementia could be met. However, this was not implemented. The strategy talked about the use of activities and therapies to meet people's individual needs and choices. But the home did not have an activity coordinator and there was not any evidence the strategy had been followed. The strategy also talked about the use of the Disability Distress Assessment Tool (DISDAT) which is a tool for recording people's calm and agitated states. When used properly it allows staff to identify triggers to both moods and allows them to identify prevention and distraction techniques to support people. The tool was not being used. We asked the registered manager what quality audit tools were being used to deliver the dementia care strategy and they did not know of any.

Staff asked people if they would like to move from one place to another when it was time for tea or time to go to the marquee. However, the timing of this was dependent on staff decisions to support people to move.

We observed how staff interacted with those people who were unable to verbally communicate and generally found interactions were poor. People were moved from the dining room to the marquee on mass and likewise back to the dining room for food. Whilst it was clear those who could verbally communicate were asked if they wanted to move between the dining room and the marquee those who could not followed behind between the two rooms.

Three people in the home who were living with dementia had support provided via a local Independent Mental Capacity Advocate (IMCA). IMCA's are used when people who lack capacity do not have family to act in their best interest. We were told by the registered manager one of these had started to work with the person and the other two were due to start.

People had a choice on the gender of the staff who supported them with personal care and people told us if they wanted a man or a woman to support them this was respected.

People told us staff knocked on their doors before entering. We were told, "They [staff] are polite and talk to me pleasantly enough."

We looked at the support people received with their glasses and hearing aids. We could see the handover document included details of when to change people's hearing aid batteries and who needed glasses and for what. However, we did not see this signed off as completed. If the document was not signed off there was a risk people who needed aids to aid them with communication and vision may not have them. We checked two people who needed to wear glasses all the time and saw they were wearing them.

A hairdresser was at the home on the day of the inspection and people were getting their hair cut and blow dried. People told us they liked this and were glad they visited the home each week so they could get their hair set. These people told us they liked to look nice.

Visitors told us they could visit the home as they chose and were offered drinks by staff when they arrived. This made visitors feel welcomed to the home to visit their family. Visitors we spoke with gave a mixed response to the quality of personalised care at the home and most blamed the lack of staff at the home for any shortfalls. This mostly related to timely support and the provision of activities that people liked to do.

Inadequate

Is the service responsive?

Our findings

At the last inspection in December 2017 we found the home 'Required improvement' for the home to be responsive. Concerns were noted around the provider meeting the individual needs and preferences of people living in the home. At this inspection we found the concerns from the previous inspection had not been addressed. We also found additional concerns which have reinforced the service provided at The Windmill was not responsive. At this inspection we have rated the provider as 'inadequate' in this area.

The inspection in December 2017 found a breach to Regulation 9 in that there were not enough activities designed to meet the needs of people living with dementia. At this inspection there was no longer an activity coordinator. We were told by the registered manager a volunteer was to begin the week after the inspection one day a week. But on the day of the inspection there was nothing going on. One person told us, "There is not enough for us to do to keep us occupied so we end up watching a lot of television." Another said, "I spend most of my days colouring in which I do like doing. We used to do games until the coordinator left but not much happens now." We found current staff did not have the time to organise and lead activities so nothing happened. There was not an activity programme or anything to stimulate people. When people do not have an opportunity to engage in activities of their choice they can become socially isolated and bored.

We found the home in continued breach of Regulation 9 of the Health and Social Care Act (Regulated Activity) Regulations 2014.

The nine people's files we looked at did not reflect the current needs and preferences of the person whose file it was. One person had a pen picture in the front of their file which stated the person's skin was to be checked daily. We were aware from information provided to the Commission prior to the inspection that this person was a very high risk of pressure damage and had broken skin in the three months prior to the inspection. This was not recorded in their pen picture. We looked at their care plan for skin integrity which had not been updated since December 2017 which stated their skin was intact. This was not the case. This meant the person's care plan was not accurate. Their assessments and associated care plans had not been updated at point of change or reviewed routinely to capture any change in their needs. This left a risk of the person receiving inappropriate care.

In another person's care plan, we saw contradictions into the support they required for eating and drinking. Their dietary profile stated their food should be cut up and they used a plate guard to support their independence. In their food and drinks delivery plan it stated they ate unaided and used usual cutlery and drinking aids. There was no clarity as to which information was most recent and which was accurate. We looked at their nutritional care plan which said the person would benefit from their food being cut up. Inconsistent messages across care plan information could lead to the delivery of inappropriate or unsuitable care and support. We found this was a similar picture across all the care plans we looked in. There was not any clear guidance on the support people needed, when or how people wanted their support to be delivered and no clear approach on how to deliver care and support in line with people's preferences and needs.

We looked at available policies for end of life care. We saw a policy for the agreement to Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR). The policy stated the person who lived in the home and was involved in the decision should undertake a capacity assessment. This should be to determine they understood the principles of agreeing to the decision. This had not been done in any of the files we looked at. People's care plans had a section titled 'Death'. We looked at this section in all the files we reviewed and noted that seven of the nine did not hold any relevant information. It was recorded 'to discuss' and 'waiting information from families'. We saw one that had detail of the person's preferred priorities of care at the end of their life but there was not any advanced care planning or discussions around practical aspects to the end of someone's life. This would allow people to influence the care they received at this time.

End of life care had not been developed or formalised. There was not a consistent approach on steps to take as someone approached the end of their life. There was not any information about people's preferences at the end of their life other than the one document we saw and the DNACPR records. Of which none had been developed in line with the provider's policy. There was no one at the end stages of their life at the time of the inspection.

This is a continued and further breach of Regulation 9 of the Health and Social Care Act (Regulated Activity) Regulations 2014.

Inside the front door by the signing in book was a box for suggestions. This box was empty on the day of the inspection. We asked people if they had ever made any suggestions to how to improve the service they received and was told no. One person told us, "There has never been a survey since I've been here, nobody has asked me what I think." Another said, "I've not been here long enough but I hope they do ask me what I think at some point."

There were results of a survey displayed in the foyer from 2016. The results were predominantly positive. We were told by the registered manager there had been one earlier in the year but the results were yet to be collated. The copies we looked at showed appreciation of the service they received.

The complaints procedure was available to people in resident information packs and on the notice board above where visitors signed into the home. We saw from complaint records that a log was kept of those received which included details of any correspondence. There were not any details of any changes made to procedures following on from the complaints received or any lessons learnt to drive improvement. However, when we spoke with people they told us they did not need to complain, as if they were not happy about something, all they needed to do was tell a member of staff and something would be done.

Inadequate

Is the service well-led?

Our findings

At the last inspection in December 2017 the home was found to 'Require improvement' for the home to be well led. We previously found the provider had not completed an effective process for auditing and improvement planning. At this inspection we found concerns from the previous inspection had not been addressed. We also found additional concerns which have reinforced the service provided at The Windmill was not well led. At this inspection we have rated the provider as 'inadequate' in this area.

The provider was found in breach of the Regulations, eight times at the last inspection in December 2017. At the last inspection the home was rated as requires improvement for each key question and requires improvement overall. At this inspection we found two of the previous breaches had now been met but six breaches remained. We have also found nine additional breaches. The provider has now been rated inadequate overall.

At the inspection in December 2017 we found the provider in breach of Regulation 17. This regulation focuses on the governance arrangements at the home. The last inspection found audits completed were not effective in independently identifying concerns. We found this was still the case at this inspection.

During this inspection we consistently found the registered manager was working as part of the staff team meeting the needs of people in the home rather than their registered manager role.
The registered manager told us at the start of the inspection that the audits had not been completed for a couple of months. We looked at the audits for accident and incident records and saw they were last completed in July 2018. We did not see any audits or monitoring of the service that had been completed any later than July 2018. Audits completed before then were limited.

We looked at the action plan from the previous inspection and noted most of the actions were still not completed. Steps to be taken to address breaches in Regulations had not been implemented and thus most of the breaches remained.

There were no internal or external processes for validation of the services provided. Records held were not contemporaneous of either the support required or the support provided to people. Records held to monitor and evaluate the service were not contemporaneous which did not allow for an understanding of the issues or concerns. When contemporaneous records are not held there is no way to assure the service delivered is in line with both standards and people's expectations. There is no way of identifying shortfalls or developing improvement plans. The structure of the home was chaotic, mostly due to a lack of suitably qualified and competent staff at all levels. This puts the people in the home at risk of not receiving support that meets their needs and staff working in the home at risk of not receiving the training and support they need to deliver that service.

The lack of contemporaneous records and effective audits to identify concerns was a concern at the last inspection.

We spoke with visiting professionals after the inspection visit and were told the registered manager had good intentions but was struggling with the work load due to their commitment to supporting staff and working on the floor. The registered manager did not have the support they needed at provider or quality manager level. We discussed this with the provider who shared with us that after the inspection that they were to recruit a head of care post to support the registered manager with holidays and days off. It was later suggested this post would be a full-time post.

All the staff we spoke with said there were not enough staff. All said they were supportive of the registered manager but were aware the registered manager was supporting them to complete the day to day support to people in the home. This meant staff felt supported by the registered manager as they were willing to pitch in when staff were short. However, this also meant that due to a lack of staff recruited in post and on the rota, there was always a lack of staff. Therefore, the home was not being suitably managed.

The concerns at the home had not been approached from a holistic perspective and actions taken were reactive to individual concerns and issues. Policies and procedures reviewed as part of the inspection were all very out of date. Some as much as six years. We were told the provider had recently signed up to an electronic care package system and new policies were to be drawn from that. Following the inspection, the provider contacted the Commission ensuring us they would roll out one new policy a week and staff would sign off to say they had read and understood the policy. However, we were not assured that this would reflect in staff implementing the policies as procedures for how they were to be implemented were still to be developed.

The lack of oversight and governance arrangements to address issues and drive improvement was impacting on the quality of care provided to people in the home. People's needs were not being met. People's needs were not being assessed and monitored to improve the quality of the service they received.

There was a registered manager in post who was registered with the Commission in August 2015. They had not been supported by a deputy for approximately three months but an administrator had been in post since July 2018. The registered manager had developed a handover sheet which included the allocation of roles and practical tasks for each shift worked. Unfortunately, this was not being completed each day so there was no formal way of ascertaining who should have been responsible for what roles and key tasks.

We took a copy of the handover record for the last day of our inspection at approximately 2.30pm. It was noted the only allocations written on the handover were the care staff for upstairs and for downstairs. Baths/showers/hair washes for people were not allocated. Support with lunchtime and tea time meals were not allocated, support with personal care and assistance to the toilet were not allocated. The records for each bedroom did not include the information requested. This included the times people got up, whether commodes were cleaned or if oral care had been provided. Pressure care relief was not recorded either on the handover document or in the room files. When we spoke with staff about this we were told there wasn't the time to complete all the tasks on the allocation so only those that could be completed by the staff available were allocated. This left people at risk of not receiving the support they required.

When records were used to monitor people's extra care needs including pressure areas and risk to malnutrition we found these were poor or not completed. We did not see body maps in use in any of the records we looked at to monitor healing wounds or pressure ulcers. These records were not monitored to ensure they were being used effectivity and to identify any increased risk making them ineffective in supporting the person with these increased risk areas.

The provider had not developed a system of governance to evaluate and improve practice. Staff were not

accountable for the delivery of the service and actions were not taken to drive improvements. This meant people were at risk of not receiving the very basic of care and a risk was also evident that staff and the manager would not know what care and support had been provided.

When providers do not have systems and processes in place to ensure they are able to meet the requirements of the regulations there is a risk they will not be met as has been evident at this inspection. This is breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014

The Commission requires registered providers to report other incidents to us in a timely way. We noted from the records reviewed that a number of accidents and incidents could have warranted a safeguarding alert. These events are also notifiable to the Commission but had not been.

When incidents are not reported to the appropriate authorities there is a risk that oversight of these incidents will be missed and where appropriate support may not be provided. This is a breach of Regulation 18 of the Health and Social Care Act (Registration) Regulations 2010.

We asked people if they had been asked for their feedback and were told predominantly no. The registered manager had attempted to hold a relative meeting in March 2018 but no one had turned up. The minutes of what was to be discussed were typed up and shared. This included training available for family members to attend around dementia awareness. An agenda had been developed for future meetings but none had been held. Resident meetings had not been held. People in the home did not have a formal route to comment or feedback on the service they received. Following the inspection, the registered manager sent us new questionnaires which had been developed and were about to be distributed. If people do not have the opportunity to feedback on the service they received, the provider has no way of assuring themselves they are delivering a service in line with both expectations and requirements.

We recommend resident and relative meetings and feedback routes become formalised.

The home worked with the local district nurse team and local GP practice to support people in the home with their health care needs. We were unable to review the impact of this support as records in the home were not updated to reflect the support provided. When records are not updated to include this information, there is a risk that additional support requested by external professionals may not be delivered to meet people's needs.

Since the inspection, the provider has worked well with both the Local Authority and Commission to ensure immediate risks to people are mitigated. The provider was issued with a request for immediate action to be undertaken to ensure the development and embedding of a governance framework to manage and implement change. We also requested an action plan to show us how the provider was to meet the requirements of the regulations which has been provided.

The Commission will continue to closely monitor the home in the coming months before the next inspection.

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 Registration Regulations 2009 Notifications of other incidents Regulation 18 (registration) regulations The provider was not submitting notifications to the commission of 'other incidents'

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) a, b, c (3) a, b, c. of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not receive appropriate support that meet their needs or reflected their preferences People were not involved with assessments of their needs and preferences. There was a lack of appropriate assessment followed by effective care planning. People's needs were not met on all occasions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The principles of the MCA were not followed. Care and treatment was provided without appropriate consent, specifically when people lacked capacity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) a, b, c of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Risks to people's health and welfare were not effectively assessed and identified. When risks were identified action was not routinely taken to mitigate risks. Staff were not supported to ensure they had the competence and skills to carry out their role safely.

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 Regulation 13 (1) (4) b of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a lack of accurate and complete assessment to support the application and implementation of restrictive practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Regulation 14 (1) (2) (a) (b) (4) (a) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Procedures in place to ensure people were in receipt of enough nutrition and hydration were ineffective

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment

	Regulation 15 (1) b, c, e of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014. The building and environment did not meet the needs of the people who lived in the home. The provider had not appropriately assessed the risks and environment routinely or when making changes to the premises

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) (f) of the health and social Care Act 2008 (Regulated Activities) 2014. Contemporaneous records were not kept of the service delivered or received. Policies and procedures were not available or up to date. This did not allow the provider to have a baseline for quality provision Risks were not identified or managed The provider did not have an effective system of quality audit

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 (1) a (2) a (3) a of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Procedures were not developed to ensure staff employed were of a good character. The required information under schedule 3 was not available

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing

Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There were not enough suitably qualified and trained staff to meet the needs of people living in the home.