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Windsor Care Home

Inspection report

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06 November 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This unannounced inspection took place on 10 September, 30 October and 6 November 2018. Our first day in September was cut short as some people living at the home were unwell.

We last inspected the home in May 2017. We found significant improvements had been made to improve the overall quality of the service. However, further improvements were still required to improve the safety of medicines, staff training and competency on the Mental Capacity Act 2005 and the effectiveness of quality assurance procedures. We reported the provider had breached the regulation relating to Good Governance and rated the home Requires Improvement overall.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question, is the service well-led, to at least good. At this inspection we found the provider had continued to make improvements to the overall quality of the service. Quality assurance checks were completed consistently and were effective in identifying areas for improvement. People, relatives, staff and health professionals gave us good feedback about the registered manager.

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

Windsor Care Home accommodates 60 people in one adapted building. There were 47 people living at the home at the time of this inspection, some of whom were living with dementia.

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.

People and relatives gave consistently good feedback about the home and the care provided. Staff and visiting health professional gave similarly positive feedback. Throughout our time at the home we observed positive interactions between people and staff.

People said they felt safe living at the home. Relatives and staff also felt the home was safe. Staff had a good understanding of the procedures for keeping people safe. For example, safeguarding and the whistle blowing procedure. They knew how to report concerns and said they wouldn't hesitate to do so if needed.

Although we observed there was a visible staff presence around the home, we received some mixed feedback about staffing levels. Management felt staffing levels were appropriate. However, the provider did not have an effective approach to monitoring and reviewing staffing levels. We have made a recommendation about this. The provider had effective recruitment procedures to ensure new staff were

recruited safely.

Medicines were managed safely. People told us they received their medicines when they were due. Records showed medicines were received, stored and disposed of correctly.

The provider completed health and safety checks and risk assessments to ensure the environment and equipment were safe. There were also up to date procedures to keep people safe in emergency situations. Staff members raised a safety issue with us about using hoisting equipment with certain specialist beds. The registered manager advised that options had been considered but had not been appropriate. However, we noted this issue had not been formally risk assessed to confirm people and staff were safe. The registered manager confirmed a risk assessment would be completed straightaway.

Staff supported people who displayed behaviours that challenge with sensitivity. Staff understood people's needs and knew the most effective strategies to follow when people were anxious.

The provider had good systems to investigate and monitor incidents and accidents. An in-depth analysis was completed every three months which reviewed these incidents and identified lessons learnt.

Staff received good support and training. Records confirmed supervisions, appraisals and training were up to date.

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

People were supported with their nutritional needs and to access healthcare services when required. We noted improvements were required to support people living with dementia to make meal choices and to ensure sufficient staff were available over lunchtime.

People's needs had been assessed. This was used as the basis for developing detailed and personalised care plans. Complaints had been fully investigated and the outcome communicated to the complainant. Complaints were analysed periodically and used to identify areas for improvement. People and staff were encouraged to give feedback about the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The home was not always safe.

Risk assessments and other checks were completed to maintain a safe environment. However, staff raised one safety concern which hadn't been adequately assessed.

There were usually enough staff deployed to meet people's needs. We noted staff were not always available during the lunchtime.

Staff were recruited effectively.

Medicines were managed safely.

Staff knew how to identify and report safeguarding concerns.

Is the service effective?

Good

The home was effective.

People's needs had been assessed.

Staff were well supported and received the training they needed.

Staff supported people with the nutritional and healthcare needs.

Adaptations had been made to the home to meet the needs of people living with dementia.

Is the service caring?

Good

The service was caring.

People felt well cared for and said the staff were kind.

People were treated with dignity and respect.

Staff supported people to be as independent as possible.

Care records were personalised to each person's needs.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed and personalised. They had been reviewed regularly to help keep them up to date.

People had opportunities to be involved in a range of activities if they wished.

People knew how to complain if they were unhappy with their care. Previous complaints had been fully investigated.

Is the service well-led?

Good

The home had a registered manager. People and staff said management were approachable.

The home had a friendly and welcoming atmosphere.

There were regular opportunities for people, relatives and staff to give feedback about the home.

Quality assurance had improved since our last inspection and was now more effective.

Windsor Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 10 September, 30 October and 6 November 2018 and was unannounced. The inspection was carried out by one inspector, a specialist adviser who was a qualified nurse and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We had regular communication with the local authority commissioners of the service, the local authority safeguarding team and the clinical commissioning group (CCG). We viewed the local authority inspection report and associated action plan.

We used information the provider sent us in the Provider Information Return. 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 spoke with six people who used the service, six relatives and two visiting health professionals. We also spoke with the registered manager, the deputy manager, two nurses, one senior care worker, three care staff, the activity co-ordinator and a kitchen assistant. We looked at five people's care records, medicines records for all people and five staff files. We also looked at a range of records relating to the management and safety of the service.

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.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us the home was safe. They also described the precautions staff had taken to maintain safety. People's comments included, "I used to fall a lot but I`ve had no falls here at all", "Oh, I feel very safe, I don't lock my door at all. I didn't feel safe in hospital but here there is always someone to call and they do come as soon as they can. Also, they look in my room about every hour to check on me so that makes me feel even safer" and "They respect you and they are very caring and worried about safety". Relatives commented, "[Family member] now has a pressure pad in case she falls" and "I`ve seen them using the hoist on [family member] … In hospital she screamed but here she is treated wonderfully."

Staff had a good understanding of safeguarding and the whistle blowing procedure. They also knew how to report concerns. Staff told us they hadn't previously needed to raise concerns but wouldn't hesitate to do so if required. Previous safeguarding concerns had been dealt with appropriately including making a referral to the local authority safeguarding team and thoroughly investigating concerns. The registered manager completed a quarterly analysis of safeguarding concerns to identify lessons learnt and check the correct action had been taken.

People and relatives gave mostly positive feedback about staffing levels. They commented, "Every time I press my buzzer they come straight away, well virtually straight away as they are often rushed off their feet", "I pressed my buzzer last night as I wanted to go to the toilet and they came straight away even though they are short staffed" and "I am totally satisfied that [family member] is being well cared for, although another member of staff wouldn't go amiss".

However, staff gave less positive feedback. They said the home was sometimes short staffed at short notice due to the unexpected absence of colleagues. One staff member said, "I feel that at times staffing levels are unsafe, and this is a common occurrence." The registered manager was transparent from the outset. He advised there had recently been difficulties with staffing but this had improved with new staff being recruited. A visiting health professional also commented they had seen improvements recently with staffing levels.

Management confirmed they felt staffing levels were appropriate. We observed there was a visible staff presence around the home. People's needs were generally met in a timely way. However, we observed there were some difficulties over the lunchtime as there were occasions when there was only one staff member present in the dining room. This presented challenges to the staff member as people displayed behaviours that challenge.

The provider used a nationally recognised tool to assess people's dependency levels. However, this only assessed people on an individual level and did not link into other information such as how many staff were on duty, busy times throughout the day and the layout of the building. This meant the provider was unable to evidence staffing levels were reviewed or analysed periodically to ensure sufficient staff were on duty.

We recommend the provider considers current best practice and uses its findings to implement a structured

approach to analysing staffing levels.

The provider continued to operate effective recruitment practices when employing new staff. This included requesting and receiving references and checks with the disclosure and barring service (DBS). DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with vulnerable people.

Medicines were manged safely. Staff had completed relevant training and had their competency assessed. We observed a medicines round and noted staff followed best practice guidelines when administering medicines. Medicines protocols described the support each person required with taking their medicines including any preferences they had. Medicines were stored and disposed of correctly. Records showed checks were carried out to ensure this remained the case. For example, temperature checks for treatment rooms and the refrigerator used to store medicines. People told us they received their medicines when they were due. One person said, "I get my medication on time."

The provider carried out a range of standard assessments, using a nationally recognised tool, to protect people from a range of potential risks. This included risks associated with poor nutrition, skin damage, mobility and pain management.

The provider continued to carry out health and safety checks and risk assessments to ensure the building and equipment were safe. Staff raised one safety concern with us regarding the location of electrical wires. Although the registered manager was aware and told us they had investigated the issue, a risk assessment was not available to confirm people and staff were safe. The registered manager confirmed this would be completed as soon as possible. People had personal emergency evacuation plans (PEEPs) which described the support they needed to remain safe in an emergency. A regular health and safety meeting took place covering topics including training, learning from accidents and incidents and infection control. Actions were identified which were followed up at subsequent meetings.

People were supported sensitively when they displayed behaviours that challenge. Care plans described the most effective methods to use when people were agitated. We observed staff following these strategies to good effect. Relatives described how staff were skilled in supporting people at these times. Comments included, "[Family member] sometimes gets very aggressive but they [staff] help to calm her. They seem to all know what she likes and doesn't like and what to say", "They have experience and keep people calm as some shout out for no reason" and "The staff have a calming effect on everyone". We spoke with a visiting behavioural specialist nurse during the inspection who told us that staff had a good understanding of the person's needs and confirmed they had made good progress since moving into the home.

People and relatives felt the home was clean. One relative said, "Everything is nice and clean and nothing is too much trouble." The provider completed a monthly infection prevention and control audit to help ensure good practice was followed. Previous audits had indicated a high level of compliance with regards to infection control in the home. This included checks of the cleanliness of the environment, training and to check staff followed good hygiene practices such as hand washing and wearing protective equipment where required. We observed staff used the appropriate equipment when supporting people such as wearing disposable aprons during meal times.

The provider had good systems for analysing incidents and accidents. This helped ensure trends were identified and learning shared with staff. For example, the registered manager had identified that part of the home was closed and people were concentrated in one area. This was contributing to the number of incidents. The latest analysis of incidents showed that following the division of the home into four smaller

units, the number of incidents had fallen. Other records showed individual incidents had been investigated and action taken to keep people safe. Action taken following incidents included reviewing care plans and risk assessments and seeking guidance from external behavioural specialists.

Good

Is the service effective?

Our findings

People and relatives felt had the required training and skills to meet people's needs. Their comments included, "They are very well trained" and "Yes [they are well trained]. They are excellent, you can't fault them."

People's needs had been assessed both before and admission to the home. This was used as a way of identifying what care people wanted and needed. It was also used to discuss whether people had any specific requirements relating to culture, religion and lifestyle. One relative told us, "[Family member] is a catholic. The priest comes at 11-30am every Sunday to give Holy Communion and brings the latest bulletins which are read out to [family member] on a regular basis."

Staff were well supported and received the training they needed for their role. They had opportunities to have a one to one supervision with management to discuss areas such as safeguarding, confidentiality, personal development and team work. Records showed supervisions, appraisals and training took place regularly. Staff commented, "We are always on [training] courses. We get (new) courses all the time." The provider determined some training as essential for staff such as fire safety, first aid and moving and handling.

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. DoLS authorisations were in place as required. The registered manager maintained a MCA matrix which identified where MCA and best interests decisions had been made, including when this needed to be reviewed. For example, where people lacked capacity to consent to their stay at the home or had restrictions placed such as for the use of bedrails and lap belts. The home also accounted for the MCA when administering medication. We observed some good practice with staff using visual strategies to help people make choices. For example, showing people plated meals to choose from where they found this difficult. However, we advised the registered manager that staff did not always follow this good practice consistently.

People and relatives gave positive feedback about the meals provided at the home. Comments included, "The food is great. I like soup and they always give me three choices as I`m a fussy eater. They know I have [medical condition] and give me food that doesn't give me heartburn", "The food is great, there is plenty of

choice. [Family member] gets porridge and bananas a lot as [family member] is a fussy eater", [Family member] had poached fish last week which they thoroughly enjoyed" and "The choice is excellent, they don't look like sludge which I think is very important … Also [family member] gets so much tea, they think [family member] is a teapot I think".

Staff supported people to access health care services in line with their individual needs. For example, care records evidenced input from a range of health professionals such as a moving and handling specialist, Community Psychiatric Nurses, the falls service, dental services and speech and language therapy (SALT). Where specific recommendations had been made these were incorporated into people's care plans to help ensure they received the care they needed.

Adaptations had been made to the home specifically relating the needs of people living with dementia. There were themed areas within the home which were appropriate to the interests of people living at the home. For example, these covered areas such as gardening and Hollywood movies. Good signage was visible around the home to help people with orientation and to locate their room. One staff member commented, "We also have a sensory room with lights, birds singing and calming water lights." Following a recent local authority inspection, the provider was implementing a programme of providing face to face dementia awareness training for all staff. This was due to be completed by the end of November 2018.

Good

Is the service caring?

Our findings

People gave consistently good feedback about the home and their care. People commented, "I`m well looked after and the carers are lovely", "They are kind and caring. They make everything light and cheerful, they chat away" and "The care is brilliant … They chat away to us all, not just to me". Similarly, relatives were happy with their family member's care. Relatives commented, "[Family member] was in here and the care was excellent", "They are very caring … What a relief it is to know that we can relax in the knowledge that [family member] is being looked after."

Throughout our time at the home, staff always supported people in a caring and supportive way. When supporting people, they explained what they were doing in a calm and patient manner. There was a quiet and calm ambience in the home.

People described how staff treated them with dignity and respect whilst at the same time promoting their independence. People commented, "They instil confidence in me and keep me independent by overseeing me walk which I find difficulty with being disabled", "They help me dress, get showered and keep my dignity when I`m getting showered. I do what I can and they do the rest", and "I do everything that I can reach when having a bath and they do the rest."

We observed how staff responded discreetly to ensure people's dignity and respect was maintained. For instance, we noted one person required assistance and was visibly upset. A staff member gave the person a cuddle and gave verbal reassurance that "everything was okay". It was apparent the person's mood lifted and they left with the staff member to receive the care they needed. A relative we were speaking with commented, "That's the care I'm talking about."

People described how staff went out of their way to meet their needs. They commented, "They even go to the shops for me during their days off", "I don't go out but that is because I don't want to. They have even gone out pricing a dressing gown for me."

The provider had received written compliments from people and relatives praising staff for the care provided. They used words such as "very compassionate" and "understanding". One relative described how staff had looked beyond their family member's diagnosis of dementia and "saw the man" their family member was. Another relative said staff had made their family member feel "happy and content".

Care records contained information about people's preferences and life history. This enabled staff to gain a fuller understanding of people's needs. When we spoke with staff they were very aware of people's needs and preferences.

People were supported to access advocacy services if they wanted. In most cases relatives advocated for people. However, some people did have independent advocates. The registered manager kept an advocacy register with details of who the advocates were and their contact details.

Good

Is the service responsive?

Our findings

People and relatives told us staff responded well to people's needs when required. One person told us about how they needed support from staff to help with a specific medical condition. They said staff stayed with then until the issue was resolved. They commented, "The staff are really good and pleasant … that's not just caring, that's dedication" Another person told us, "I can't think of anything that they wouldn't try to do for you and the care is excellent, especially if you are not feeling well". Another relative told us about one occasion when their family member had fallen. They commented, "They [staff] rang me within the hour. If [family member] had been at home they may not have been found for days but here they were checked on every hour on the hour." Another relative told us about how staff had replaced a broken personal item at no cost to the person. They said, "It may not seem much to you but to [family member] and me it was marvellous".

Care plans reviewed were person-centred and tailored to meet the needs of individual people. They clearly described the care each person needed. They covered a range of needs including nutrition, personal care and communication.

Care plans were reviewed consistently every month. Most people told us they chose not to be involved in their care planning or reviews. One person said, "My son sees my care plan and gets a report about me whenever he comes in. They ring him when I`m poorly and keep me safe." Another relative told us, "I am updated regularly on how [family member] is doing and when I say regularly I mean daily."

People had the opportunity to discuss their end of life wishes and these were included in their care plan. We spoke with a relative whose family member had previously been cared for at the home. They said, "It was such a relief to know [family member] was here, especially during [family member's] final few weeks. I knew they were treating her as one of their own family." The provider used nationally recognised tools to identify whether people required palliative care.

People had the opportunity to participate in a range of activities if they wished. The activity co-ordinator told us about what was available. This included bingo, cooking, ball games, karaoke and themed events such as for Halloween. We saw many photographs taken of people taking part in these activities. One relative told us, "I would come in at various times during the day and evening and sometimes they would be reading to [family member] and holding [family member's] hand." Another relative said, "The activities are good, varied and stimulating. They have regular sing songs and bingo with nearly everyone joining in." An activity timetable was displayed in the reception area advertising a range of group and one to one activities. These included a baking club, arts and crafts and bingo.

Although we only received positive feedback about the home, people were confident to raise concerns if needed. One person said, "The staff would sort out any problems … not that we have any as everyone looks after you and takes care of you." Previous complaints had been fully investigated and a written response given to the complainant. The registered manager completed a quarterly analysis of complaints which aimed to identify areas for improvement. For instance, improving the quality of note-taking and additional

face to face training relating to supporting behaviours that challenge.

Good

Is the service well-led?

Our findings

When we last inspected Windsor Care Home we found the provider had breached the regulation relating to Good Governance because it lacked an effective quality assurance process. Since our last inspection the provider had made improvements to the quality assurance programme operated at the home. We found these were now more effective in identifying issues and ensuring appropriate action was taken. Audits covered a range of areas such as the quality of care planning, infection control, clinical areas and health and safety. An external audit had been completed in September 2018 which was focused around CQCs five key questions. An action plan had been developed following this audit.

The home had an improvement plan which was progressing well. This was developed following the last local authority inspection. This included actions focused around training, improving how information was analysed and increased health and safety checks. Most actions had been signed off as completed and we saw these were embedded into working practices. For example, we saw complaints, safeguarding issues and incidents were being analysed thoroughly every three months.

People and relatives gave very positive feedback about the registered manager. One relative described them as "very hands on." Another relative commented, "It is very well led and that has obviously filtered down." Staff also told us management were approachable and would not hesitate to speak to them if required. One staff member said, "[Registered manager] is great, approachable. He listens." Another staff member told us, "[Registered manager] is alright, you can talk to him."

People and relatives described the home as having a friendly atmosphere. Their comments included, "It's a very good, friendly atmosphere here and the manager has a good, reliable team working with him", "They create a home from home and create a lovely ambience, but more importantly treat [family member] as one of their own family. Unless you have a loved one in a home you can't begin to comprehend how much of a comfort that is to us" and "The atmosphere here is excellent and I have full confidence in everyone from the cleaners to the manager".

There were opportunities for people and relatives to provide feedback about the care provided at the home. This included attending residents' and relative's meetings and completing questionnaires. One relative told us, "I do go to the meetings and I raised the subject of more staff but was told that the staff to resident ratio is acceptable." Minutes showed regular meetings took place at various times of the day to encourage maximum attendance. Topics discussed included improvements to the home, safeguarding, health and safety and confidentiality. Likewise, staff meetings were also held frequently.

People, relatives, advocates and visiting health professionals had been formally consulted about their views of the care provided at the home. The survey covered areas such as views about the quality of care, the meals provided, cleanliness, activities and how involved people felt. 22 people took part with most responses being positive. Where a negative response had been received, the registered manager responded directly to this. For example, five people felt the menu could be more varied. Action taken to address this included menus to be reviewed with input from people and relatives and arranging an open afternoon for

them to sample the new menu choices.

Staff told us the registered manager and deputy manager encouraged and listened to feedback, One staff member commented, "The manager and deputy are very open to new strategies and ideas that improve care". For example, one staff member told us about how they had suggested improvements to people's care records which had been taken on board within the home. Staff had also implemented a 'dressings file' to improve the quality of information available to new and agency staff about wound care.

Relatives and staff also described a feeling the home had made improvements. One relative said, "If anything it seems to have improved over the last 12 months. There has been a massive improvement in the last year."

Records we requested were stored securely and readily available. Records were completed accurately including records to show what care people had received, such as food and fluid intake charts.