HC-One Limited

Windsor Court

Inspection report

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24 March 2021
09 April 2021

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Windsor Court is a residential care home providing personal and nursing care to 48 people aged 65 and over at the time of the inspection. The service can support up to 77 people. The service is split into four units across two floors.

People's experience of using this service and what we found

Systems in place to monitor and improve the quality of the service had not always been effective. Areas identified at this inspection had not been addressed. Improvements were required to ensure effective communication with people's relatives and staff.

There was not always enough staff to meet people's needs. Systems in place to assess the staffing levels and rota staff on shift were not always accurate.

The environment was not suitably maintained, for example attention was required to some flooring and carpets.

Records were not always fully detailed or accurate. This included medication records, care plans and risk assessments.

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

A new senior management team was supporting the service. They were in the process of auditing the service and making improvements but required further time for these to be embedded and sustained.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last inspection was a targeted inspection therefore the service did not receive a rating (published 18 March 2020). This meant the provider kept the rating of good from the previous inspection published 20 November 2018.

Why we inspected
We received concerns in relation to infection control and from our internal monitoring systems. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions

were used in calculating the overall rating at this inspection.

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

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the maintenance of the building, staffing levels and systems to monitor and improve the quality of the service at this inspection.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Windsor Court

Detailed findings

Background to this inspection

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

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

Inspection team
This inspection was carried out by two inspectors and one specialist advisor. An Expert by Experience made telephone calls to relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Inspection activity started on 24 March 2021 and ended on 09 April 2021.

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

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. This information helps support our inspections. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with staff on site and via telephone. We spoke with the registered manager, the area manager, unit manager, registered nurses, nursing assistants, senior care assistants, care assistants and domestic staff. We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed. We made telephone calls to nine relatives.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, rotas, dependency tools and a variety of quality assurance records. We received feedback from two health and social care professionals.

Requires Improvement

Is the service safe?

Our findings

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

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

Staffing and recruitment

- There was not always enough staff on shift. Staff told us they had to be task focused and were not able to provide person centred care. One staff told us, "You don't get enough time with the residents to do things like self-care, you don't have time to talk to them you just have to get them washed and dressed quickly, you have to be really quick."
- Some staff told us they had to provide care on their own to people who required two carers.
- Staff did not have time to carry out tasks such as answering the phone and promoting contact with relatives during the COVID-19 pandemic.
- Rotas were not always accurate or up to date.
- The provider used a dependency tool to assess staffing levels. For one person this was not accurate, and we could not be assured due to the lack of monitoring the dependency tool was accurate to meet people's needs.
- Health professionals told us staff were not always consistent so did not have the knowledge to support appointments.

Failure to provide sufficient numbers of staff is a breach of regulation 18, (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- After the inspection the new area manager had increased the staffing levels on one unit and was looking at proactive ways of covering shifts. The deputy manager confirmed following the inspection they had been made supernumerary.
- Recruitment checks had been carried out to ensure staff were safe to work at the service.

Preventing and controlling infection

- Areas of the home were not maintained to a good standard. For example, handrails and door frames where chipped down to the wood, some carpets required replacing and flooring was not fully sealed.
- Equipment such as pedal bins were not always in place to allow PPE to be disposed of safely.
- Some people's bedrooms required attention to ensure they were maintained. Two people had holes in their en-suite doors. One person's furniture required replacing.

The failure to maintain the premises was a breach of regulation 15, (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were somewhat assured that the provider's infection prevention and control policy was up to date
● We were somewhat assured that the provider was using PPE effectively and safely.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider was preventing visitors from catching and spreading infections.

Assessing risk, safety monitoring and management
● Risk assessments and care plans were inconsistent or not fully detailed to mitigate the risks to people.
● Not all people had a call bell at time of inspection to request support should they require it. The registered manager added regular checks to her walk around to reduce the risk of this happening again.
● Monitoring systems were not always fully completed or monitored correctly to reduce the risks to people's health. For example, weight records, must scores, fluid monitoring and bowel monitoring.

We recommend the provider reviews their process for monitoring and reviewing the risks to people's health.

● The area manager confirmed they were carrying out clinical reviews to ensure only people who required monitoring charts had these in place so these systems would be more effective.

Using medicines safely
● Medicines records required improvement. For example, records for medication that was prescribed 'as and when required' were not always in place or did not contain sufficient information.
● When people required their medication covertly. Records did not contain sufficient detail, for example what food the medication should be given with.
● Health professionals' feedback was that improvement was required with the management of medicines.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Staff had received safeguarding training and knew the process to report any types of abuse.
● People and their relatives told us they felt safe, "I do feel [Name] is safe and well looked after."
● Staff completed accident and incident forms; these were monitored by the registered manager.

Requires Improvement

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Governance systems in place had failed to monitor and improve the quality and safety of the service. They had failed to address the areas identified at this inspection.
- Records were not consistent in quality across the service. Some records were not accurate or fully completed. This included people's care plans, risk assessments and monitoring charts.
- Systems to monitor risks to people's health were not effective as records were not completed or monitored correctly. For example, people's fluid charts had no target total, and these had not been signed and checked so action could be taken if people were not having sufficient fluid intake.
- Although incidents had been addressed, they had not always been looked at as whole to address the culture or the service. For example, different incidents of staff speaking to or in front of people inappropriately.

The provider failed maintain accurate complete records and to improve the quality and safety of the services provided which was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A new senior management team were in post at the service and were in the process of auditing and making improvements to the service.
- The new area director was passionate about developing the service and supporting the registered manager.

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

- People's relatives felt communication was not always good with the service, this included during the COVID-19 pandemic. Previous concerns had been raised regarding the communication from the service in the relative's surveys.
- Relatives and health professionals told us they were not always able to get through on the phones. Not all relatives felt staff knew people well in reviews.
- The provider had made the decision not to undertake staff surveys to gather their views during the COVID-19 pandemic.
- We received mixed feedback from staff. Not all staff felt listened to and that communication could

improve.

The was further evidence of a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People were happy with the care they received. However, the lack of staff meant staff were not always able to provide person-centred care.

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

● Appropriate notifications were submitted to CQC and the local authority.

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 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to maintain the standards and hygiene of the service. 15(1)(a), 15(1)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of the service. The provider failed to mitigate the risk to people's safety. The provider failed to keep accurate and contemporaneous records. Regulation 17 (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure a sufficient number of staff were suitably deployed. 18(1)