Midland Heart Limited

Willowfields

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on the 4 and 5 November 2015 and was announced. We gave the provider 48 hours' notice that we would be visiting the service. This was because the service provides domiciliary care and we wanted to be sure that staff would be available.

We found concerns in March 2014 with the amount of care staff working to ensure people were kept safe. We asked the provider to send us an action plan outlining how they would make improvements and we considered this when carrying out this inspection.

Willowfields is registered to provide personal care services to people in their own homes as part of an extra care scheme. On the day of the inspection, 23 people were receiving support from the service in their own home. A recently appointed manager was in post who had applied to register to manage the service, there was however a registered manager still in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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 told us the service they received was safe, but there was not always enough staff to ensure the support people received was consistent.

Medicines were generally administered safely, although errors had been made which people said was due to the inconsistent staffing situation.

Whilst we found that the provider had a procedure and guidance in place around the Mental Capacity Act 2005 (MCA), care staff had limited knowledge of the impact of the MCA on people and staff were not all receiving MCA training consistently.

Other than this, we found that staff were supported sufficiently to do their job.

People told us that care staff were 'Caring', 'Compassionate' and 'Kind'. Our observations confirmed this.

People's privacy and dignity was being respected.

People told us they were involved in the care planning process, this ensured they were able to make choices and decisions about the support they received.

The provider had a complaints process which people told us they were aware of and knew who to complain to.

People, relatives, professionals and care staff told us the service was not well led as there was not a regular manager in post and not enough care staff.

The provider made available a suggestion box and questionnaire to gather people's views about the service and they were also able to attend regular meetings with the registered manager.

Notifiable events were not being reported to us consistently as required within the law.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

People told us they felt safe, but there was not always sufficient staff to keep them safe. People, their relatives, care staff and health care professional all shared concerns about the level of staff not being enough.

People were not always happy with how their medicines were being administered.

Requires improvement

Is the service effective?
The service was not always effective.

People told us their consent was always sought. The provider had appropriate guidance and procedures about the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, care staff knowledge was limited about the MCA and DoLS.

Training in the MCA was not always available consistently to ensure staff had the skills and knowledge to support people appropriately.

Care staff told us they were able to get support when needed.

Requires improvement

Is the service caring?
The service was caring.

Care staff were caring, compassionate and kind to people.

People told us they were able to make choices and how they were supported.

People's privacy and dignity was respected.

Good

Is the service responsive?
The service was responsive.

People were involved in the assessment and care planning process.

People were aware of who to complain to where they had a complaint.

Good

Is the service well-led?
The service was not always well led.

People told us the service was not well led due to there not being a regular consistent manager and enough care staff.

People were able to share their views on the service in a number of ways.

The provider did not ensure that all notifiable events were reported to us as required by the law

Requires improvement

Willowfields

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.

Our inspection took place on 4 and 5 November 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. Due to how small the service is the manager is often out of the office supporting staff and we needed to be sure that someone would be available.

The inspection was carried out by three inspectors.

We asked the provider to complete a Provider Information Return (PIR), which they did not return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information is then used to help us plan our inspection. To plan our inspection we also reviewed information we held about the service. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law.

We visited the provider's main office which was located within an extra care scheme. We spoke with three people who used the service, three relatives, five staff members, three visiting health care professionals and the manager who had been appointed four weeks prior and had not yet taken over the registered manager role from the existing person. The registered manager was not present on the day of the inspection. We reviewed the care records of three people that used the service, reviewed the records for four members of staff and records related to the management of the service.

Requires improvement

Is the service safe?

Our findings

When we last inspected this service in March 2014 we found a breach in Regulation 22 of the Health Social Care Act 2008 (Regulated Activities) Regulation 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. This was because we found that the provider did not have enough care staff working to ensure people were kept safe. We asked the provider to send us an action plan outlining how they would make the necessary improvements.

We found at this inspection that there were still concerns being raised that there were not enough care staff. People told us there was not enough care staff. One person said, "I use to have regular staff, now I get staff who do not know my needs. That tells me there is not enough staff". A relative said, "Agency staff are not as good as permanent staff. They aren't friendly and don't speak". Other relatives told us that there was not enough staff and particularly on Fridays and at weekends. We spoke to a number of health care professionals who were visiting people on the day and they told us that care staff changed quite regularly, they would see new staff all the time. A health care professional said, "I worry about staffing levels. Sometimes I feel they need more staff". Care staff we spoke with told us that there were not enough staff to support people safely. They told us there were a number of vacancies that needed to be appointed to which meant there were a lot of agency staff covering shifts. The evidence we saw confirmed this and also identified that only one of the four night time care staff positions were recruited to.

We found from the action plan we were sent that not all the actions the provider told us they would take had been actioned. Where cover was required due to vacancies or absences the provider told us they would use their own bank staff to ensure people were supported appropriately and consistently. We found that agency staff were still being used on a regular basis. This left people not receiving the quality of service they expected. On one occasion we were told that two agency staff working together on their own on an entire shift without established staff led to a mistake with the administration of someone's medicines. The manager acknowledged the situation had taken place and told us that action had been taken to ensure agency staff would no longer work together on their own. We also found that care staff were still being expected to be in two places at once (i.e. supporting more than one person at the same time) with no travelling time being allowed. Any checks taking place on this were not effective as the allocation of care staff time was still being duplicated.

We found that the senior role position had been reduced from three permanent positions to two and only one position was currently appointed to. The manager along with a care staff member who was acting up were being required to cover the reduction in senior care staff hours. The staff we spoke with told us they were stressed and struggled at times to manage the situation. We also found that there had been an increase in the amount of people who needed two care staff to support them from two to five. The manager who had only been in post four weeks was unable to answer our concerns fully however told us that interviews were taking place and every effort was being made to appoint care staff to the vacant post.

The care staff we spoke with told us that they completed a Disclosure and Barring Service (DBS) check as part of the recruitment process before being appointed to their job. These checks were carried out as part of the legal requirements to ensure care staff were able to work with people and any potential risk of harm could be reduced. We found that the provider had a recruitment process in place so they were able to ensure all new recruits had the appropriate skills, knowledge and experience to be appointed. We found that references were being sought from previous employers to check the character of potential staff.

People told us they felt safe. One person said, "I definitely feel safe here". A relative said, "Absolutely believe mum is safe". Care staff we spoke with were able to give examples of what abuse was and told us they had received training in safeguarding people and what action they should take to keep people safe. One member of the care staff said, "I would inform a senior and manager. I would take it higher if needed like the police". We saw evidence that confirmed that care staff received training and the provider had a procedure in place to ensure care staff knew what to do where they had concerns about people being kept safe.

People told us their medicines were not always managed appropriately. A person said, "They [care staff] give me my medicine on time and leave my lunchtime one for me as I can take that myself. They check the medicine by counting how much they have given me". Another person said, "One girl is panic stricken when doing my medication. In my

Requires improvement

Is the service safe?

opinion she shouldn't be allowed to do it. I have to reassure her. Staff are not trained enough to do my tablets, only one or two". The person went on to tell us of a recent situation where there were error made with the administration of their medicines. We discussed this with the manager who confirmed staff had not followed the medicines procedures and action was taken to ensure the staff concerned received further training and a safeguarding alert raised. Care staff we spoke with told us they were not able to administer people's medicines until they had completed training. They told us the training was updated yearly and their competency to administer medicines and spot checks were carried out regularly and we saw evidence to confirm this.

The provider had a medicines procedure in place that gave care staff the information and guidance they needed to administer people's medicines appropriately. Where people were administered medicines 'as required' we saw that a protocol was in place to give staff the guidance they would need to know the circumstances in which these medicines could be given safely. Care staff we spoke with were able to explain how these medicines were administered and showed an understanding about the protocols in place. A Medicine Administration Record (MAR) was being used to identify when medicines was given.

We found that risk assessments were in place to identify where there were risks to how people were supported and how they were to be managed or reduced to keep people safe. Care staff we spoke with were able to explain how they knew what potential risks there were to people and the process to follow to ensure people were safe.

Requires improvement

Is the service effective?

Our findings

People told us that their regular permanent care staff knew what they were doing when they supported them. One person said, "I do feel staff have the skills to support me". Another person told us the staff were trained well. A relative said, "They [care staff] do seem to be very well trained and know what they are doing". The care staff we spoke with told us they did get regular supervision and a yearly appraisal and felt supported. The evidence we saw confirmed that care staff were able to get the support they needed. Staff meetings were taking place on a regular basis and staff were able to get access to the appropriate training to meet people's needs. One care staff member said, "When I started I shadowed staff as part of my induction". We saw that when staff needed support, senior care staff and the manager were available.

People told us that their consent was sought before care staff supported them. One person said, "They do ask permission but they don't have to do a lot for me". While another person said, "They always ask me before doing anything". Relatives we spoke with told us that staff would not do anything without seeking consent. A member of the care staff told us, "Everyone here has capacity to state what they want and don't want".

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

Care staff we spoke with had an inconsistent understanding of what the MCA and deprivation of Liberty Safeguards (DoLS) was and how it could impact on people. Care staff we spoke with all told us they had received training but were not all able to explain how this legislation would affect how they supported people. We saw that training was taking place but not all care staff had received the training. We discussed our findings with the manager who was able to explain the MCA and DoLS to us. They told us they would ensure training was made available to all care staff. The manager confirmed that no one within this service lacked mental capacity and therefore would not fall within the MCA.

People told us that they were able to access a good quality of meal. Care staff were also able to support people where needed with a meal within their home. Some people were at risk of choking or diabetic and could only eat certain meals. One care staff member told us, "We encourage healthy eating and we shop for some people's meals, although it's their choice. One person I support is diabetic so I am aware of their needs. They also have a thickener and they know why. They have good communication skills so we talk about it being of benefit to them".

One person said, "If I need the doctor and can't ring him, staff will do it for me". We saw evidence that people had access to health care professionals. On the day of the inspection there were three healthcare professional in the scheme supporting people in a range of ways. We saw that records were kept to show when people were seen by their doctor, dentist, optician and what the outcome was from the visit or any planned follow up. There was also information on hospital visits or planned appointments.

Good

Is the service caring?

Our findings

People told us that the permanent care staff were kind, professional and nice. One person said, “Staff are caring and friendly. We have a laugh and a joke”, another person said, “The staff are friendly and like to stop and chat with me”. A relative told us, “Staff are caring, they [staff] will stroke [person’s name] arm for encouragement and speak to her at her level rather than at her. They [staff] are compassionate, friendly and always smiling”. We observed staff being compassionate, reassuring and caring to someone who was unwell.

People told us that staff listened to them. One person said, “Staff help me to make decisions but it is always up to me”. Another person told us that they made the decisions about the support they had. A relative told us, “Staff were always doing what [person’s name] wanted she made the decisions not the staff”. Care staff we spoke with were able to tell us that people made their own choices about the support they were given. A care staff member said, “I give people the options and enough time to decide what they want me to do”. Our observations were that people were able to make their own decisions and do what they wanted.

We saw that people who were supported by care staff were also able to live their lives independently and had overall control as to what they did and when they went out.

Information was available to support people in making their own decisions and was available in a range of formats. People told us they could also discuss things with the care staff. We saw where people had monthly meetings that minutes were available for people to understand the discussion that took place and the decision and actions that resulted from the meeting. One person said, “I go to residents meetings, but I don’t like talking in front of other people. They [staff] put the notes through the door to let me know that a meeting is coming up”. We saw that people were able to share their views with staff and the manager whenever they wanted.

People told us that their dignity and privacy was respected. One person said, “Yes staff do treat me with dignity”. Relatives we spoke with told us that the support their relatives received from care staff was respectful of their dignity and privacy. The care staff we spoke with were able to explain how they ensure people’s privacy and dignity was respected. One member of the care staff said, “I keep the door shut when I am providing personal care”, whilst another care staff member said, “I always ask if people are comfortable, cover people over when I am doing personal care and continually talk to them and ask them if they are okay”. We saw evidence that training in respecting people’s dignity was available to care staff so they had the skills and understanding when they were supporting people with their dignity and human rights.

Good

Is the service responsive?

Our findings

People told us that they were involved in the assessment and care planning process and took part in a review. A person said, "I was involved in in my care planning and I was asked my opinion". A relative told us they were involved in the care planning process. Care staff we spoke with told us that reviews were carried out every three months and changes were noted. Another person said, "I came into the service on a low package of care, but at my review my care was increased". We saw that reviews were taking place and as people's support needs changed their care package changed accordingly to meet their needs.

We found that the service offered was such that people were able to live their lives independently. A person said, "I was asked if I have any preferences or religious needs before I moved in". This meant that staff knew people as individuals and what they likes and dislikes were.

We found that care staff were able to access equality and diversity training to support their knowledge and understanding in being able to meet people's needs. We saw that as part of the assessment process this question was asked to ensure where people had support needs in this area it would be planned for as part of the care planning process.

People we spoke with told us they knew who to complain to if they had a complaint. A person said, "I would just go to the office if I had a complaint", another person told us they were offered support to make a complaint. Relatives we spoke with told us if they had a complaint they would go to the manager. Care staff we spoke with knew about the complaints process and were able to explain the actions they would take if someone had a complaint. We saw evidence that the provider's complaints process had a complaints log so when complaints were made they were able to make a note of when the complaint was received and ensured it was resolved within their own timescales. We found that a monitoring process was in place to ensure timescales were being met.

Requires improvement

Is the service well-led?

Our findings

We found that the provider was not notifying us of all notifiable events within the home as is required within the law. We saw evidence that safeguarding alerts raised with the local authority were not being notified to us.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People, relatives, professionals and care staff told us the service was not well led due to the inconsistency of a regular manager and not enough care staff. We found that there had been a number of managers in post over a short period of time leading to the inconsistency. People told us they were hopeful the service would be better led now that a permanent manager had been appointed who would probably be in post for a while. They all spoke highly of the newly appointed manager. One person said, "New manager is A1. I am very much happy". A relative told us, "I can't fault the manager, she is polite and professional". A care staff member said, "The new manager seems really passionate but we have had so many managers that morale is low so I'm hopeful we are going to be well led".

We found that the area manager was registered to manage the scheme and did this during the period of there being no permanent manager. The recently appointed manager had applied to be the registered manager. We found that there was a management structure that staff knew and were aware of who they should contact if the registered manager was not available.

People told us the manager was seen carrying out spot checks on how care staff supported them. A relative told us that they always saw the manager walking about and checking on what staff were doing. We saw evidence of the quality assurance checks that had been carried out by the manager and checks the provider carried out to ensure the standards they expected people to receive were being achieved. These checks did not identify any of the staffing concerns we found. The manager told us they would be taking action to ensure all staff had travelling time and continue with the recruiting of new care staff.

Care staff we spoke with were able to explain how they would handle accidents and incidents and how these situations would be recorded. Evidence showed that the provider had a procedure in place to guide staff when dealing with these situations. One staff member said, "These are logged on the computer, when where and who. I write up a detailed report and sign it. Senior reads it and keeps it in the office. We try to learn from incidents and put measures in place". We saw evidence that where these incidents or accidents happened the provider monitored trends as a way of reducing accidents.

We saw evidence that people were able to share their views whenever they wanted by speaking with the registered manager at regular monthly meetings. The provider also used questionnaires to gather people's views on the service. A relative said, "I have had a questionnaire to complete". A care staff member said, "I filled in a survey about the service yesterday". We found that the provider had a system in place to gather people's views on the service they received including the use of a suggestion box in reception, which people were aware of. However, the questionnaires did not seem to be sent to everyone consistently. The manager told us this would be looked into for future questionnaires.

We found that the provider had a whistleblowing policy in place. This gave care staff the opportunity to raise concerns about the service anonymously. Care staff told us they knew about the whistleblowing process and how and when it should be used.

We found that the provider did not return their completed Provider Information Return (PIR) as we had requested. The manager informed us that the PIR had not been received.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The intention of this regulation is to specify a range of events or occurrences that must be notified to CQC so that, where needed, CQC can take follow-up action. Providers must notify CQC of all incidents that affect the health, safety and welfare of people who use services. The full list of incidents is in the text of the regulation. All providers must send their notifications directly to CQC unless the provider is a health service body, local authority or provider of primary medical services and it has previously notified the NHS Commissioning Board Authority (now known as NHS England). CQC can prosecute for a breach of this regulation or a breach of part of the regulation. This means that CQC can move directly to prosecution without first serving a warning notice. Additionally, CQC may also take any other regulatory action. CQC must refuse registration if providers cannot satisfy us that they can and will continue to comply with this regulation.