Culpeper Care Limited

Willow Tree Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 3 and 4 October 2016 and it was unannounced.

Willow Tree Nursing Home is provided by Culpepper Care Limited. Willow Tree Nursing Home provides accommodation, personal care and support and nursing care for up to 47 older people. The home has two units. Cedar unit provides accommodation for older people living with complex health care conditions and physical frailty. Oak unit provides accommodation for older people living with dementia and physical frailty. At the time of the inspection 44 people lived at the home.

Willow Tree Nursing Home was last inspected by us in March 2016 and we found breaches of the regulations. These related to the safe care and treatment of people and the need to gain people's consent and the governance of the home. We gave the service an overall rating of 'requires improvement' and asked the provider to send us a report to tell us how improvements were going to be made to the service provided. At this inspection we found the provider had not implemented their planned improvements to meet the requirements of the regulations.

The home is required to have a registered manager in post. 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 and associated Regulations about how the service is run. At the time of this inspection the home had a registered manager in post.

Systems in place to assess the quality of the service provided were not always effective and improvement had not been fully implemented as planned. Risks associated with the management of medicines and people's care and treatment had not been identified by checks undertaken. Feedback was sought from people and their relatives but negative comments were not always investigated or acted upon. The registered manager did not always investigate concerns about poor care practices raised with them.

There was not a system to ensure that the management of medicines was done safely. People had not always received their medicines as prescribed because they had run out. Discrepancies in stock and records meant we were not able to check that some medicine had been given as prescribed as the amount of medicines available did not match the records of receipt or administration.

Assessments to identify where people may be at risk of harm or injury did not always ensure that the risk was minimised. Some risks had not been assessed and staff did not have the information available to refer to, if needed, to know how to minimise risks.

Most people felt safe living at the home because staff were there to support them when needed. A few people did not feel consistently safe at night because they had experienced people entering their bedrooms. Staff were trained to know what abuse was and how to report any concerns to the registered manager.

Staff worked within the principles of the Mental Capacity Act (MCA) 2005 when supporting people with personal care. The provider used closed circuit television surveillance in communal areas of the home but could not show us how they had consulted with people and their families about its use. The registered manager had not always acted in accordance with the MCA. People's liberty was only restricted when the proper authorisation had been sought.

People had choices offered to them about what they wanted to eat and drink and were supported to maintain their health and see a GP, for example, if they felt unwell.

Staff had received training and felt this gave them the skills and knowledge they needed to meet people's needs effectively. Staff promoted people's privacy when they were supported with personal care.

People felt most staff were kind and had a caring approach to them, however, this was not consistent with all staff. Some people felt a few staff were not always caring. People felt involved in making decisions about their day to day care and how they spent their time. There were planned group activities for people to take part in if they wished to do so and people told us they enjoyed group activities and trips out.

We found a number of breaches of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. 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 inspected 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 take action 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 within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

People did not always receive their medicines as prescribed and guidance was not consistently available for staff to ensure people received their medicines in a safe way. Nurses did not always follow the provider's policy when administering medicines, which posed risks of harm to people. Risks were not always effectively assessed, and actions to minimise harm or injury had not always been taken.

People did not consistently feel safe living at the home. Staff were trained to know what abuse was and how to report any concerns, however, the registered manager did not always investigate concerns raised with them about poor care practices.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had undertaken training to deliver care and support to people. Staff worked within the principles of the Mental Capacity Act (MCA) 2005 when supporting people with personal care. The registered manager had not always acted in accordance with the MCA. The requirements of the Deprivation of Liberty Safeguards were followed. People were offered choices and enjoyed the food and their nutritional needs were met. People were supported to maintain their health and were referred to health professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People felt most staff were kind and caring towards them but this was not consistent. Overall, whilst people were involved in decisions about their day to day care, such as where they spent their time, they or their relatives, had not always been involved in decisions about their care and treatment. People's privacy was promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Most people felt that overall their care needs were met by staff, but this was not consistent and we identified times when people's needs were either not met or not met in a way appropriate to them. There were planned group activities for people to take part in if they wished to do so, which people said they enjoyed. Feedback was sought from people and their relatives, but this was not always recorded by staff and had not always been acted upon.

Is the service well-led?

Inadequate

The service was not well led.

Sufficient improvement had not been made to the provider's systems and processes to monitor the quality of the service provided and to ensure these were safe and effective. Management and staff did not demonstrate an understanding of the principles of good quality assurance. This meant that a number of shortfalls continued in relation to the service people received that had not been identified or improved.

Staff told us they felt supported by the registered manager, but felt improvement was needed in the management of the service.

Willow Tree Nursing 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.

The inspection took place on 3 and 4 October 2016 and was unannounced. On the first day of the inspection, the inspection team consisted of two inspectors, a pharmacy inspector and an 'expert by experience.' An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of care service. We told the provider we would be returning on the 4 October 2016 to complete our inspection. On the second day, the inspection team consisted of two inspectors and an expert by experience.

The provider had completed a provider information return (PIR). 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.

We reviewed the information we held about the service. This included information shared with us by the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. We reviewed statutory notifications sent to us from the provider. A statutory notification is information about important events which the provider is required to send us by law. We reviewed feedback sent to us from relatives who had 'shared their experiences' with us and from other professionals, such as solicitors, who had involvement with people living at the home, such as managing their finances on their behalf. Some of these people had shared concerns with us about the home, such as examples of poor care being given to people and the cleanliness of the home being poor.

Many of the people living at the home were not able to tell us about their experiences of living at the home due to their complex health conditions. We spent time with these people and observed the care and support they were given by staff using a Short Observational framework for inspection (SOFI) in the communal lounge area. SOFI is a way of observing people's care to help us understand the experience of people who live there.

We spoke with ten people who lived at the home and 11 relatives or friends, who told us about their experiences of using the service. We spoke with staff on duty including four nurses, ten care staff, a team leader, one cleaning staff, the cook, the activities staff member, the (non-clinical) deputy manager, the registered manager and the operations manager.

We reviewed a range of records, these included eight care records and 14 medicine administration records (MAR). We looked at quality assurance audits and feedback sought from people.

Inadequate

Is the service safe?

Our findings

At our inspection in March 2016, we identified multiple breaches in the regulations regarding the safe care and treatment of people. The provider did not always manage medicines safely. The provider did not take always protect people against potential risks or take action to mitigate such risks. The provider did not ensure people were cared for by staff that had the qualifications, competence, skills and experience to do so safely. The provider had not taken measures to prevent and control the risks of infection. In March 2016, we rated the area of safe 'inadequate.' At this inspection, we checked whether the provider had implemented improvements to meet the regulations. We found sufficient improvement had not made, or sustained, in providing safe care and treatment to people living at the home.

On the first day of our inspection visit, we saw nursing staff did not administer medicines safely or in accordance with the provider's medicine policy. One nurse prepared more than one person's medicine for administration at the same time, which posed a potential risk of people receiving the wrong medicines. Records showed the nurse had also signed to say one person had been given their medicines, but we found these were out of stock and could not have been given. When we informed the registered manager and operations manager about this, they told us it was an agency nurse that had, "worked at the home on a regular basis." Immediate action was taken by the registered manager and operations manager to address these issues and we were informed the agency nurse would not be undertaking further shifts at the home.

Despite another nurse's assurance that the out of stock medicines would be delivered on the second day of our inspection visit, they were not delivered until the following day. The medicines had not been ordered when they should have been and the person was not able to take their prescribed medicine for more than 48 hours. No action was taken to obtain an emergency supply of medicines from a pharmacy to ensure this person's health and wellbeing were maintained.

The 14 Medicine Administration Record (MAR) charts we looked at, showed that medicines were not always managed, administered or stored safely. The amount of medicines recorded as 'administered' and 'in stock' was not accurate. We were not able to check that some medicine had been given as prescribed for three people because the total amount of medicine available did not match the records of receipt or administration. Two people on inhaled medicine to aid their breathing were not receiving the dose that they had been prescribed. Records of the amount of medicine inhaled did not match the prescribed amounts, which meant people had received less of their inhaler than they needed and had been prescribed.

Medicines with a short expiry date were not always dated when they were opened and were not always disposed of when their expiry date was reached. This is particularly important for insulin which has a 28 day expiry when it is removed from a fridge. We found insulin for two people that had been removed from the refrigerator, but there was no record of the date it had been removed and staff were unable to tell us. This meant the insulin could have been out of the fridge for longer than the recommended 28 days and there was a risk the medicine was unsafe to use. Another person's eye drops in the fridge were no longer safe to use because they had passed their expiry date.

Improvements had not been made in the administration of medicines given to people 'covertly;' that is, when medicine is put in to food or drink without the person's knowledge. We found insufficient information available to inform staff how to prepare and administer medicines safely when given covertly. For example, the pharmacist had highlighted two medicines as 'not safe to crush or chew with food,' but a nurse told us they were given to the person hidden in food and the person often chewed them. The nurse could not be confident this was safe because they had not sought advice from a pharmacist or the person's GP.

We found some improvement in the guidance and information about medicines to be given 'when required,' however, this was inconsistent and was missing for some people. This meant the operations manager and registered manager had not ensured all staff had sufficient information about people's 'when required' medicines, to ensure they were given to people in a consistent and safe way.

Records for people who were prescribed their medicine through skin patches were inconsistent. Whilst some recorded the location on a person's body where a skin patch had been applied, some did not. Medicinal skin patches were not being applied and removed in line with the manufacturer's guidance, which meant people were at risk of experiencing adverse side effects.

Staff did not follow safe practice in administering 'homely remedies.' Homely remedies are 'over the counter' medicines purchased and agreed with a person's GP to give for minor ailments for a short time. The provider's policy, and authorisation from the GP, allowed a maximum of two days treatment with these medicines. Records showed some people were given more than two days treatment without being referred to the GP. We identified some homely remedy medicines had passed their expiry date and had been administered to people. For example, a bottle of simple linctus had expired in November 2015 but had been administered to a person in April 2016. The operations manager informed us the items would be disposed of safely.

Medicines were kept in locked trolleys in a corridor. We identified that this was not in line with the provider's medication policy. We found there was no assurance that medicines had been stored at a safe temperature. We found improvement had not been made to ensure people's MARs were stored securely when they were not being used by the nurse. On both days of our inspection visit we saw people's personal information was stored on top of the medicine trolleys in communal areas of the home and these were left unattended. One staff member informed us people's MARs were stored on top of the medicine trolley in the corridor when they were not being used.

This was a continued breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's safety and welfare were not always identified, so action to minimise risk was not planned appropriately. For example, two people who lived at the home smoked cigarettes. Both of their care plans identified some risks, for example of 'developing a bad chest.' However, other risks related to smoking were not identified. For example, neither person's plan included actions to minimise the risks of the person accidentally dropping a lit cigarette on their clothes, such as making a fire retardant clothing cover available. Neither person's care plan required staff to stay with the person while they smoked, but neither person was independently mobile. Neither person's care plan required the person to sit at a distance from the external doors and windows, which meant other people were exposed to cigarette smoke while sitting in their own or communal rooms. There were no appropriate waste bins for cigarettes, which meant the stubs were left on the ground, where other people might be tempted to pick them up. There were no written plans to protect staff, who chose not to smoke themselves, from the risks associated from passive smoking.

We observed that whilst risk assessments had been completed to offer guidance to staff where people were at risk of developing sore or damaged skin, staff did not consistently ensure the risks of damage was minimised. We saw one person, who was unable to communicate their needs verbally, had a hoist sling under their body whilst sitting in a special armchair. A large plastic buckle had been left under this person's skin and was digging into them. This was removed so this person's skin would not be damaged. We discussed this with the registered manager. They told us the hoist sling should not be left under this person's body and they would order a more suitable hoist sling that had no plastic buckles.

Some people said they felt safe living at the home because staff were there to support them if needed. However, a few people told us they did not always feel safe, this included people living on Oak and Cedar. One person said they did not feel safe because they could not shut their bedroom door and other people who lived at the home came into their room at night. They said the people who came in their room at night re-arranged their possessions and sat in their chair. They added two pairs of their glasses had been lost. This person explained to us that night staff did not ever see the other people in their room because they did not come round and check them regularly. The person said, "They (staff) are supposed to check you, but they don't." We saw the person's bedroom door did not have a handle, catch or latch and could just be pushed open. We shared this feedback with the operations manager, who said they would investigate. Another person also said they did not feel safe at night due to someone entering their bedroom, and standing over them whilst they were in bed. The registered manager told us this issue had been resolved because a pressure sensor met was now being used to alert staff when a person got out of bed and was known to walk about and enter other people's bedrooms. However, reassurance had not been given, by staff, to the person that felt unsafe at night.

Staff understood their responsibilities to share any concerns if they believed people might be at risk of abuse. Staff said if they witnessed abuse, they would challenge this and share their concerns with the registered manager. However, we identified examples of when a relative had raised concerns and the registered manager had not followed the provider's policy. The registered manager had not recorded poor practices as 'adverse incidents' and they had not investigated the concerns to fulfil their responsibilities in ensuring people received safe care and treatment.

This was a continued breach of Regulation 12 (1) (2) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people felt there were not always enough staff on shift to support them when needed. One person told us, "Sometimes I wait for ages" and "sometimes the bell isn't working." Another person said, "I need staff to help me to the toilet, I can't get there on my own. Sometimes I have to wait and wait." Another person told us, "Yesterday, I had to wait for breakfast. I was told the 'breakfast lady' was off and had breakfast about 11am. Today, I asked staff if they would help me have a wash before my visitors arrived, but they haven't. It's gone 11.00 o'clock and I've not even had a wash since yesterday. I am really upset about it."

People who felt there were enough staff on shift, were those that required less support. The registered manager informed us they used a dependency care profile to inform staffing levels. However, we found these were not always accurate. For example, one person's dependency care profile had not been updated since their discharge from hospital. However, this person's care plan had been reviewed and recorded as 'no changes.' We observed there were changes in the person's needs, compared to the information in their care plan and their level of dependency had increased. This meant the dependency care and risk profile used to inform staffing levels was not always accurate.

Care staff told us there were usually enough staff on duty to support everyone according to their needs. The nurse on duty told us there was usually one nurse, four care staff and a person to serve breakfast on duty in the mornings in Oak unit. However, during our inspection visit we identified a few staff that came on duty, who were officially on a day off. The registered manager told us they had come in to 'help out' because of our inspection visit.

One nurse employed by the provider told us, "I know the manager is trying to recruit nurses, but there is basically not enough of us (nurses employed by the provider) to ensure things are done. Agency staff don't have the same level of responsibility." The registered manager told us they used agency nurses and care staff at the home to cover shifts, with an average of 300 hours a week provided by agency staff. The registered manager informed us they had three nurse vacancy positions and said, "One nurse is due to start work in November, but we are finding it difficult to recruit. We will still have vacancies, but try to use the same agency nurses for consistency."

One care staff member told us they had recently started working at the home. They told us, "Before I started, the manager told me they would do checks, like getting references from people about me. The manager then contacted me and said I could start, I'm just getting to know people and used to the routine of the home at the moment." This meant that the provider's recruitment process involved checks being made to ensure staff were of good character.

Nursing staff were confident they knew how they would deal with emergencies, such as a fire or accidents that might arise from time to time. One staff member explained they would get the nurse in charge and follow their instructions. One nurse gave us examples of first aid they would give for incidents that might occur, such as a person choking. The operations manager told us they had enough staff qualified in first aid to ensure every shift had a nurse or other staff member that knew what to do in the event of an emergency.

At our last inspection we found the provider had not managed risks related to infection prevention and control and was in breach of the regulations. Prior to this inspection, we had received some complaints from people's relatives about the lack of cleanliness in the home. At this inspection we found some improvements had been made but further improvements were required. Improvements had been made in the kitchen, which we saw was clean. The cook told us, "I work additional night shift hours, this is when deep cleans are done in the kitchen. It would be impossible to fit in the cleaning when I am preparing meals during the daytime." Further improvements had been made to the overall cleanliness of Oak and Cedar kitchenettes. Plastic lidded containers had been purchased and were used, in people's bedrooms, to store incontinence pads and clinical items such as dressings for skin.

The registered manager informed us that some planned improvements had not yet been implemented. For example, we identified some equipment had not been replaced, such as a shower chair where rust prevented effective cleaning. We identified some further improvements were required to prevent and control the risks of infection and these included the daily cleaning hours scheduled.

On the first day of our inspection visit, there was one cleaner on shift for six hours covering Oak and Cedar and we were informed there had been no cleaner working on the previous two days. People's bedrooms and the communal areas were generally clean and tidy, but there were areas where carpets were sticky to walk on. We discussed this with the registered manager and they told us an internal applicant had applied for the post of housekeeper. On the second day of our inspection we saw this staff member working alongside two other cleaners. One cleaner told us, "It is much better today with three of us. Occasionally I've been on my own, and it's an impossible task with just one."

At our last inspection visit, we identified some areas of the home were in need of maintenance. At this inspection, we found some improvement had been made, for example, new external doors had been fitted to Cedar lounge. However, some issues had not been attended to, such as a hole in one person's ensuite toilet door. The registered manager informed us they had identified they were not allocated sufficient hours for their maintenance staff to meet the needs of the home and had arranged for support so décor issues could be improved. Redecoration of some corridors was taking place on the first day of our inspection. The operations manager informed us this was a part of a rolling programme to refurbish the home and this had been commenced during August 2016.

Following our feedback to the registered manager and operations manager, immediate action was taken to implement further improvement. For example, equipment was ordered and we were told this would be that would be in place before the end of October 2016. The operations manager stated 112 hours a week were allocated to cleaning, by housekeeping staff, and believed these hours, inclusive of the newly appointed head of housekeeping, would be sufficient to maintain the cleanliness of the home.

Requires Improvement

Is the service effective?

Our findings

At our inspection in March 2016, we identified a breach in the regulations regarding the requirements for the registered manager and provider to act in accordance with the Mental Capacity Act (MCA) 2005. We told the provider improvements were needed. At this inspection, we found some planned improvements had not been made. We found the registered manager had not always acted within the principles of the MCA.

The Mental Capacity Act 2005 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.

The registered manager told us all but four staff had recently received training in the MCA. Staff told us they had training in the MCA and understood their responsibilities under the Act. Care staff told us, "You can't force people to sit down if they like to walk about." We observed staff worked within the principles of the MCA.

However, we found the registered manager did not always understand their responsibility under the MCA. We looked at a 'best interests' meeting for one person which recorded the registered manager had agreed, with a relative, for a web-camera to be placed in their family member's bedroom. The registered manager told us the person was unable to give consent themselves to this, but was unable to explain what risks had been identified that would be managed by the use of the web-camera, and therefore why it was in the person's 'best interests.'

At our last inspection, we found no evidence of how people living at the home had been consulted, by the provider, about the use of Closed Circuit Television (CCTV) in communal areas of the home. Although there were notices in the home to inform people of the use of CCTV, people were not always aware it was in use. One person told us, "I didn't know there were cameras inside this home," and one relative said, "I wasn't aware of camera used in the home, I thought they were on the outside." We found the service user guide had not been updated since our last inspection and still did not inform people about the use, and purpose, of CCTV in the home. The decision whether to use surveillance is for care providers to make in consultation with the people who use their services, their relatives and staff. We found this had not taken place.

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

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 are called the Deprivation of Liberty Safeguards. On this inspection visit, we found improvement had been made and the registered manager and provider were acting in line with the requirements of the Act. The registered manager informed us that ten people were deprived of their liberty and they applied to the supervisory

body, for the authority to deprive a further 32 people, of their liberty, because their care plans included restrictions to their liberty. For example, they could not go out independently, because they did not recognise risks to their safety outside of the home. The registered manager told us they had applied for DoLS for all but two of the people who lived in Oak unit, because the doors were locked by a key code. Two people, who had the capacity to choose, had chosen to live on Oak unit because they preferred those rooms. People's care plans were marked with a coloured symbol to remind staff when a DoLS had been authorised.

At our last inspection we had identified gaps in staff training records, and had been told by the registered manager that not all staff had completed all of the training they needed. At this inspection, we found some improvement had been made, however, some care and nursing staff had not completed all of the training they needed. For example, one of eight nurses had completed infection prevention and control and two of eight nurses had completed safeguarding people from abuse. The registered manager told us some staff were completing distance learning care courses but they did not have a training plan in place to show us. Following our inspection, the operations manager told us they had a training program in place and sent this to us, which meant there were plans to address gaps in staff's training.

Overall people and their relatives felt staff had the skills they needed for their role. A member of care staff told us during their induction they had training and shadowed staff, observing how they delivered care and support. They told us they learnt about people's individual needs and they felt prepared to work independently. A member of staff told us that agency staff had an induction to the service if they had not worked at the home previously.

Three staff told us they attended training in subjects that were relevant to people's needs, for example, training in infection prevention and control, dementia awareness, equality, diversity and human rights and in moving and handling. One member of staff told us some training was delivered face-to-face and some was on-line and said the training was 'good' because they had a better understanding of how to care for and support people after training.

Despite staff's training, we saw not all staff demonstrated they had learnt from their training and now had an understanding of how it might feel to live with dementia. For example, when one person who was agitated called out, a member of staff answered them from across the room, but there were more than 20 people in the room, and several conversations in progress, so the person who was agitated would not have known the member of staff was responding to them. The person remained agitated and continued to call out.

People told us they enjoyed their meals. One person said, "I choose to eat in my bedroom, the food on the whole is good, choices are a bit repetitive like toad in the hole and liver and bacon but there are two choices each day. If I need anything to eat or drink, I ask the staff and don't have to wait too long." Another person said, "The food is good, we have choices." We saw staff offered extra portions to some people but not to people who required a soft puree food diet. One staff member told us, "We never have any extra soft puree food, so can't offer this to people." We asked if this had ever been requested from the cook, but was told it had not.

Not everyone was supported to enjoy their mealtime experience. People who needed assistance to eat were assisted by a member of care staff. Most care staff sat beside the person and spoke encouragingly to people while they assisted them. Staff took their time and people were supported at their own pace. One member of staff did not sit quietly with the person they were assisting, but kept standing up and responding to other staff across the room. The staff in charge of the shift did not take control of the moment and remind staff of their primary duty to support the person to enjoy their meal. Another person was seated, by staff, in an

armchair directly next to a bin and served their meal. This bin was used, by staff, while this person ate their meal, which showed staff had not given consideration to this person and the enjoyment of their meal or the potential risks of infection.

People's care plans identified where they may be at risk due to poor nutrition, but staff did not always take action to minimise the risks and this was not always monitored by the nurse in charge. For example, one person was at risk of poor nutrition and their care plan said they should have been weighed weekly to monitor whether the actions taken by staff to improve their nutrition were effective. However, this person's weight was recorded once in June, July and August, but in September, their record said, "scales broken". There was guidance in the care plan for how to 'estimate' the person's body mass index, as an indicator of their weight, but no staff had made the measurements. Staff had not assessed whether the person had lost or gained weight, so they could not know whether their intervention of assisting the person to eat was effective.

Another person had declined to be weighed because it caused them pain, however, staff had not given consideration to other ways of monitoring their weight. A further person's weight was recorded as an estimate and we asked a nurse what this had been based on. The nurse told us this person was quite poorly and it caused them distress to weigh them, however they could not tell us how the estimate of 'between 37 and 43 kilograms' had been determined. When we asked the nurse about their knowledge of using a person's arm measurement, they were able to tell us how this was done and said, "We should really use that more I suppose when we cannot weigh people."

Some people had Malnutrition Universal Screening Tool (MUST) assessments. (MUST) is a management plan for people who are malnourished or at risk of malnutrition. The cook told us they minimised the risks of malnutrition by adding extra calories to milk and porridge and offered high calorie snacks, such as full fat yogurts or cheese, to people between meals. Although the cook did not have any written information about people's needs, they knew people well because they had worked at the home for several years. We found improvement had been made to the snacks made available to people at risk of malnutrition. For example, we saw one person help themselves to the bowl of fruit on the table and other people enjoyed home-made cakes during the afternoon.

During our inspection visit, we saw that people were offered drinks. Where people needed to have their fluid intake monitored, charts were available for staff to record details about people's food and fluid when needed, however, we found staff did not consistently complete these or provide details of amounts eaten. Details of a person's desired fluid intake was not always recorded, amounts of fluid taken were not always totalled and there was no evidence of action taken by staff, if a person's fluid intake was low. For example, according to one person's fluid monitoring chart, they had not drunk anything for 19 hours, between 5.00pm on 1 October and 10:00am on 2 October, and had not drunk anything for 20.5 hours between 3:30pm on 2 October and 10:05am hours on 3 October 2016. Whilst this person did not exhibit signs of dehydration, the member of staff in charge of monitoring people's health and wellbeing had not identified this lack of recording as an issue. The registered manager told us, staff were expected to complete the charts throughout their shift and said improvement had been made but not consistently sustained.

Staff supported people to access healthcare professionals when needed. Most people felt they saw a doctor when they felt unwell. One staff member told us, "If we are worried people are not well, we tell the nurses. They listen to us." We observed one person tell a nurse they had mouth pain and the nurse arranged for an urgent dental home visit that took place on the second day of our inspection. An optician visited the home on the second day of our inspection visit and introduced themselves to staff. Some people had appointments for eye tests and were supported by staff to attend these in the home.

The registered manager told us, one of the eight GP practices that people were registered with, one was proactive and visited the home every Tuesday, to check their patients' health was maintained. The registered manager explained some people chose to be registered with different GP practices in the local area, though in their experience found these were not as proactive in visiting people at the home, but gave telephone guidance to staff.

People's care plans included records of visits by other health professionals and of the advice they gave. People's daily records showed they followed the health care professionals' advice, for example, by keeping their feet elevated.

Requires Improvement

Is the service caring?

Our findings

At our inspection in March 2016, we identified improvement was needed to ensure staff consistently took a caring approach toward people. At this inspection we continued to receive mixed responses when we asked people if staff were caring. We observed most staff had a caring approach to people, however, this was not consistent.

Some people told us most of the staff were kind and thoughtful. One person said, "[Staff Name] will do anything for you, but lots of them have accents I don't understand." The person told us they often felt like staff were 'telling them off.' They said if they called out for support, staff told them off for shouting and said they should use the call bell, but 'only if they needed something'. Another person told us, "I urgently needed staff in the night and shouted out for them, when they came to me, one of them told me off for shouting and not using the bell. Some staff are kind but not all of them." As a part of the provider seeking feedback from people, they asked people 'Are staff kind and helpful?' We saw some positive feedback had been given, but a few people had made negative comments such as 'some are not.'

Most relatives felt staff were caring toward their family member. One relative told us, "The staff are fantastic, they are patient with my family member when they change their clothes all the time, they love having their hair done, staff do their fingernails and today they are having their feet done." Another relative said, "I think the staff are absolutely caring, my relation has been here ten years and I couldn't wish for better care for them."

However, people and their relatives were not always actively involved in making decisions about their care, treatment and support. One relative informed us their family member, who lived with dementia and did not have the capacity to make their own decisions, was moved from Cedar where they had lived for over a year to Oak. This relative told us, "I was very angry as staff had not consulted me. My family member was very unhappy with the change to their routine. I requested they were moved back to Cedar, which staff arranged."

Not all staff demonstrated an understanding of how dementia impacted on people's ability to understand jokes. One member of staff maintained a cheerful and teasing form of conversation, but did not seem aware they could confuse or agitate people with their words and approach. We heard the member of staff say on several occasions, 'Don't worry, I am only joking' when people did not smile in response to their words. The person in charge of the shift did not challenge the member of staff's approach and behaviour, so they continued to misunderstand the importance of using appropriate words and behaviour.

People did not all receive person centred care. Care staff told us they did not have time to read people's care plans, but said they knew people well enough to understand how they liked to be supported. However, when we asked staff about people they were not always able to tell us about them. For example, one staff member told us, "I don't really know [Person's Name] as they are quite new here, but I know they are a hoist and a double up." This staff member was unable to tell us anything about the individual as a person, only about the practical aspects of caring for them showing their approach was task led.

Some staff had got to know people well over time. A member of staff told us if people were not able to express themselves verbally, they were still able to make their feelings known to staff. They told us, "People explain themselves through their hand movements and we watch their facial expression and eye movements."

Improvements were needed in making people feel as if it was their home. People's rooms contained their personal mementos and photos, but their bedroom doors were not personalised to enable them to find their own room easily. Most bedroom doors did not have the person's name, photo or any distinguishing feature.

The provider's policy for keyworkers did not promote a person centred culture, but a task led culture. Each person had a named allocated keyworker, but this was related to the person's room number, not to any shared interests or lifestyles. A member of staff told us keyworkers were responsible for changing beds and keeping people's clothes and rooms tidy, but not for any particular role in advocating for, or representing the person's interests.

People were unable to recall if they were involved in 'resident meetings.' However, some relatives told us they were aware of these. The registered manager informed us they had held a resident and relative meeting in September 2016, however this was only attended by three relatives. Some relatives had told us they had not noticed information displayed in the reception area of the home. The registered manager agreed emailing or texting relatives to inform them of planned meetings could be a more effective way of keeping them informed about the home.

People were supported to maintain their dignity related to their appearance. Everyone we saw wore clean clothes, and their nails were clean and manicured. People were encouraged to wear clothes protectors when they ate, to protect their clothes from spills. We saw staff were observant of people's appearance and offered them tissues to wipe their mouths after eating.

However, staff did not always demonstrate understanding of how a person's dignity was affected by their environment. One person who preferred to spend time in their room told us staff regularly forgot to shut their toilet door. This meant they spent most of the day looking at the toilet, because this was the way their chair faced. The person was not able to walk independently, so could not close the toilet door themselves. Their room was too small to change the layout of the furniture. We shared this feedback with the operations manager, who said they would investigate the possibility of the person changing rooms where they would have a more comfortable environment.

Staff told us people's relatives and friends were able to visit them at any time and there were no restrictions. One person told us, "Yes, my family can visit me when they want and they have taken me out for meals" and one relative told us, "I can come in at any reasonable hour and I visit every day."

Requires Improvement

Is the service responsive?

Our findings

At our inspection in March 2016, we identified improvement was needed in how staff responded to people's needs. At this inspection we continued to receive mixed responses when we asked people if they felt staff met their individual needs. We observed occasions when staff delivered personalised care and met people's support needs, showing some improvements had been made. However, we identified occasions when staff did not always met people's needs and were not responsive to their requests for support.

One person told us staff were not responsive to their needs. They told us they preferred to spend time in their bedroom, but they were always cold because there was a draught from the side door; next to their bedroom, which was always open. Throughout our inspection visit, we saw this door was left open and one staff member told us, "It is good to let the fresh air in." Another staff member said this person complained of being cold, but did not always want to put a cardigan on, when staff offered this to them. The person told us they liked to have their own door open because they didn't like to feel 'shut in'. We shared this feedback with the operations manager, who said they would investigate the possibility of the person changing rooms so they were not next to the garden door and the constant draught.

One person's care record said they should have their catheter changed every 12 weeks, however, we saw the last recorded change was during May 2016, which was at least 16 weeks previously. Catheters can stay in place from between two to 12 weeks before they need to be changed. If they are not changed there is a risk to the person, such as urine infections or blockages in the tubing preventing effective draining of urine. We pointed this out to a nurse and they said, "This person usually reminds us when it is due to be changed and it should be in the diary." The nurse checked the records and agreed the person's catheter had not been changed. We asked the nurse to take immediate action to mitigate the risks of infection and they did.

Staff were not always present to respond to people's needs for support. Although there was a member of staff present in Oak communal lounge all the time, staff confirmed this did not happen in Cedar lounge. Most people in the Cedar lounge were not be able to call out to staff or able use a call bell to gain staff attention if needed. A staff member told us, "Staff are not always in the Cedar lounge. The three people at highest risk of falls spend each day on Oak because staff stay in the lounge there, but we might be away from the lounge (Cedar) for half an hour or so, but not more than an hour even when it is the busier times." The member of staff had not understood that responding to people's needs required more thought and person centred interventions than 'falls prevention.'

Some people were cared for in their bed because they were frail or poorly. We saw staff ensured people who were able to use their call bell were left with it accessible to them, so that they could ring for staff if needed. However, some people were not able to use their call bell due to their health conditions and staff told us these people were checked every two hours. One staff member said, "We pop in and make sure they are safe in bed." These checks did not involve spending any time with people and we observed the only contact people had with staff was when tasks were completed. We found no assessment had been completed to determine the length of time between checks or how risks of social isolation were minimised for people who were unable to gain staff attention if needed.

Care plans included a section entitled, "My life story". One person's life story included details of their interests, so staff had information to help them understand the person's interests and the topics of conversation they would be interested in. The record included the fact that the person wished to be supported to regularly attend their church. A member of staff told us the person used to be supported by staff to attend their church, but the person had become too poorly and frail to continue attending the service. Staff told us the person now attended a church service at the home every week instead.

Of the eight care plans we looked at, seven included the section entitled, "My life story", but four were blank. This might have been because the person was not able to tell their story, or because they or their relatives did not want to share their stories. However, staff had not taken the time or opportunity to add their own knowledge about people's individual interests and enthusiasms to this document. Staff's knowledge about supporting people to maintain their interests and preferred pastimes was dependent on staff's individual observation or verbal information sharing.

People could not recall being invited to or taking part in a review of their care and support. However, some relatives said they felt involved in their family member's care planning and reviews. One relative told us, "We have had meetings with staff but not for a while." Another relative said, "I had a review meeting last week." Records showed people's relatives were invited to care plan reviews to make sure people were supported to discuss their needs with the support of a person they trusted and who knew them well.

People were supported to spend time in activities they were interested in and to socialise with others. One person told us, "I go to the bingo, coffee and cake days and I have been on some of the outings, and [Staff Name] is very good at organising these." Another person said, "The activities co-ordinator organises days out and entertainers and they are very good"

We saw the activities co-ordinator encouraged people to join in group and one to one activities. On the first day of our inspection, people took turns to throw a soft ball into a basketball hoop on the floor. We saw people concentrated hard on their aim and smiled to themselves when they threw the ball accurately into the hoop. One person was supported to do a jigsaw puzzle, while the activities co-ordinator read a book aloud to another person. On the second day of our inspection visit, we saw a group of people attended a craft session, which gave them the opportunity to handle different materials and colours and to stimulate their senses.

The activities co-ordinator told us they asked people about their interests when they moved into the home and organised one-to-one and group activities that people said they would like. They told us people loved playing dominoes, baking cakes and had planted the herbs and rhubarb in the raised beds in the garden.

Overall, people felt positive about activities in the home, although one person commented when the activities co-ordinator was not at the home, there was 'nothing' available in terms of activities.

Most people and their relatives told us they had no current complaints about their care they or their family member received. One person told us, "I have no complaints, I know who to go to if needed. When I told the manager I wanted a quieter bedroom, they moved me to this quieter room." Another person said, "I've never had to make a complaint in over two years living here."

However, some people told us about concerns about missing items such as glasses and items of clothing. Some relatives told us about concerns, although they had not all brought these to the attention of the registered manager, who informed us they were not aware of these concerns.

The provider's complaints policy and procedure was not implemented effectively. The registered manager informed us that one complaint had been received by them during 2016. However, people and relatives made us aware of other concerns they had raised with staff verbally but these had not been recorded. A few relatives informed us of concerns they believed were being investigated by the registered manager, however, we found no record of them and the registered manager told us they were not aware of the concerns having being raised with staff. This meant that issues may not always have been investigated or resolved and could not be used an opportunity to learn and improve the service because they were not always recorded.

Inadequate

Is the service well-led?

Our findings

At our inspection in March 2016, we identified a breach in the regulations regarding the governance of the home and told the provider improvements were required. They sent us an action plan, setting out the actions they would take to improve, and the date by which each action would be taken. At this inspection, we found actions in the provider's action plan had not all been taken and some actions that had been taken had not brought about the required improvements.

At our inspection in March 2016, we identified the quality assurance audits were not always effective and had not identified issues we had found. At this inspection, we found some improvement had been made, such as with the infection prevention and control audit. We found actions had been identified where improvement was needed, however, timescales and those responsible for the improvement were not always recorded. Some straightforward, practical steps to reduce the risks of infection had not been taken. For example, at our last inspection we identified a rusty shower chair that we had identified as a risk, because effective cleaning could not take place. This had not been replaced and was still in the bathroom, staff confirmed it was still used.

The registered manager had failed to ensure that medicines were managed and administered safely. Some quality assurance audits had not improved and were ineffective. We looked at two medicine management audits completed during June 2016 and September 2016. We identified the June 2016 had missed issues we identified, for example the effective monitoring of homely remedies in the home. We found the action plan from the September 2016 audit did not check issues we had identified where improvements were needed.

The registered manager was not able to demonstrate that they identified, recorded and analysed medicine errors. They informed us there had not been any medicine errors during the eighteen months they had been in post as registered manager. However, we identified medicine errors. This meant that there was no opportunity for staff to learn from past mistakes and there was an increased likelihood that the same error could happen again, putting people at risk from repeated errors.

The registered manager failed to ensure people's medicines were administered by staff with appropriate skills and competencies. One staff member told us the management team observed their competencies sometimes, by observing their work practices. However, two agency nurses we spoke with told us they were not aware of their competencies ever being assessed by the management team. One nurse told us, "I am an agency nurse but have been coming to this home for years, the manager has never observed me administering medicines to people."

Another nurse said, "When I started working here a few years ago, as a part of my induction the manager did a medicine competency assessment but I've not had any more since." The registered manager informed us they completed staff competency assessments informally and formally. The registered manager said, "If something is observed that needs addressing, then I would speak with staff. Some recorded medicine competency assessments have been completed and more will be done, but I have not included agency staff in these." Opportunities to monitor the practices of all staff working at the home were missed and necessary

improvements to their practices were not identified.

We found the nurse's diary system to record that people's clinical health needs were met was not always effective. There was no process to check entries were made to remind nursing staff when routine and regular tasks should be completed. Staff could not explain how frequently checks were made by the registered manager or provider to ensure people's nursing needs were met. Fluid monitoring charts, for people at risk of poor hydration did not include targets, were not completed consistently and were not totalled every 24 hours. The registered manager had not identified this issue during their system of checks, so could not be assured people regularly had enough to drink. We found there was a lack of oversight from the registered manager and provider to ensure people's personal clinical health needs were completed as required.

Systems in place to audit the quality of services through feedback were not always effective. The registered manager told us, "We sent out feedback surveys to people and their relatives during May 2016." Of the 35 feedback surveys sent to relatives, 15 had been returned. The registered manager had analysed the feedback to identify areas of satisfaction and dissatisfaction. For example, 61.8% of people felt if they needed to ring their call bell, it was answered promptly. However, the registered manager was not able to demonstrate they had investigated why 38% of people did not think their call bell was answered promptly. An action plan was in place to make some improvements but this had not taken the opportunity to, for example, improve the speed of response to call bells.

We were told some people living at the home had completed 'smiley face' feedback surveys because these were more accessible to them to complete. However, we saw some of the completed forms referred to another care home, when asking questions about the quality of the service. It was therefore unclear whether these related to people's feedback about Willow Tree Nursing Home or whether the wrong forms had been used, which people may have found confusing. Some people had given positive feedback by ticking a happy 'smiling face', however, other people had given negative feedback by ticking an 'unhappy face.' We found that the analysis and action plan from people's feedback had not always been used to improve the quality of the service.

Incident and accident analysis was not effective, because the written records did not capture all the available information. The registered manager informed us that all accidents and incidents were recorded as an 'adverse incident' and a monthly analysis took place to make sure actions were taken to reduce the risk of reoccurrence. We saw 32 incidents were recorded for July 2016 and 20 for August 2016. People's care records showed us that on an individual level, actions were taken to reduce the risks. For example, we saw one person had a pressure sensor mat placed next to their bed to alert staff if they got out of bed in the night. However, we identified events that had occurred but had not been recorded as an adverse incident. The registered manager told us they had been made verbally aware of these events but had not recorded them. The operations manager said they should have been recorded in line with the provider's policy.

Care plan audits were not always effective because they did not identify when care plans and dependency profiles had not been updated. For example, the eight care plans we reviewed were all marked as 'reviewed' every month. However, we observed people's needs had changed since their care plans were written, but the guidance for staff had not been updated to meet people's changed needs. The registered manager's care plan audits had not identified that some people's care plans no longer matched their needs and abilities and had not been reviewed effectively.

Our observations demonstrated that people's quality of life was not included in the provider's system of quality assurance checks. The registered manager assessed the needs and abilities of people who lived with dementia against a specific framework, to identify how dementia impacted their physical abilities and their

abilities to communicate their needs. The dementia assessment records did not state whether the assessment was based on other records, staff's knowledge or whether the assessor had sat and observed how the person spent their time and how they actually behaved and responded to staff's intervention. One issue that we raised with the operations manager, about how a person was cared for and supported, demonstrated the registered manager had not spent time observing how the person spent their time as a measure of the quality of the service. Management and staff did not demonstrate an understanding of the principles of good quality assurance, which meant opportunities to identify where improvements were required, were missed.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the staff felt improvements had been made since our last inspection. One staff member said, "Lots of things have improved for people, the manager has encouraged us to offer and support people with more snacks and drinks, there are more activities for people and the care given is better." Another staff member said, "I think things are better than they were, the manager has improved the care given to people. Some things still need to improve, like staff completing the records and making sure people are always okay, rather than waiting to be told to do things."

All the staff we spoke with told us they liked working at the service, though they all said improvements were needed in the management of the service. Staff told us this included all levels of management. For example, one staff member told us they were not confident that all staff recognised a team leader's authority to manage and lead a shift. They told us that some staff did not listen to the team leader.

Staff felt the registered manager was approachable and listened to them. One staff member told us, "The manager is good at advice, support and guidance" and "I feel respected and appreciated by them" and "I get feedback and feel encouraged. The manager listens." A nurse told us, "The manager listens. They are a good person." Some staff felt although they could raise issues with the registered manager, they did not always act or give feedback on any actions taken. For example, the activities co-ordinator told us they had asked the registered manager to check with the provider whether there was a budget for 'social activities', so they could plan effectively. They had not received an answer and planned to ask again in writing. They told us previous requests for individual items, such as jigsaw puzzles and board games had been agreed, but without a budget, it was hard to plan and schedule trips, events and entertainers. They told us the cost of entertainment and activities was mostly dependent on 'goodwill' and unpaid 'volunteers,' such as staff supporting events on their days off. Another staff member told us, "Sometimes the manager's hands are tied and they might like to do something but it is up to the providers."

A member of staff told us they had identified some improvement could be made to the quality of the service. They told us the service would be improved by better organisation of staff, more time to keep proper records and to give more time to people. They told us they thought this could be achieved by having more staff.

A nurse told us improvements were needed in retaining staff to ensure continuity of care for people. They told us improvements were needed in maintaining staff's loyalty and commitment to ensure the provider's policies and processes were understood and followed by all staff.

On the second day of our inspection visit, the operations manager informed us they had become aware, during September 2016, that some planned improvements they had told us would be implemented following our last inspection had not been implemented. The operations manager said they would be implementing supportive processes for the registered manager to ensure improvements were made.

We gave feedback to the registered manager and operations manager on the second day of our inspection visit. Following this, the operations manager sent us an action plan telling us about 'immediate actions' they were taking to make improvements to the issues we had identified to them. These included improvement to the management of medicines and carrying out a stock audit of people's medicines so that people did not run out of their medicines. The operations manager informed us there would be a review of all quality audits during October 2016 and action taken when improvements had not yet been implemented as planned for.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent had not always been sought.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (1) (2) (b) (c) People were not always protected against potential risks and actions were not always taken to mitigate such risks.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have a safe system to manage medicines. Medicines were not always managed, administered or stored safely.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems and processes to monitor the quality of the service provided were not effective.

The enforcement action we took:

Warning Notice