

# Maria Mallaband Care Homes Limited

## Willowdene Care Home

### 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?	Requires Improvement 
Is the service well-led?	Requires Improvement 

# Summary of findings

## Overall summary

This inspection took place on 22 May 2018 and was unannounced.

Willowdene is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is registered for 47 people and at the time of inspection there were 39 people living at the service. The service had three units, nursing which had 17 people living there, residential which had 11 people and a unit which specialised in care for people living with dementia, which had 9 people.

A registered manager was in post at the time of the inspection visit. They were registered with the Care Quality Commission on the 15 May 2018. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was last inspected in December 2015 and received a rating of Good. At this inspection we found the service was now rated requires improvement.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These concerns related to the safety of people using the service and the lack of oversight of the service. You can see what action we told the registered provider to take at the back of the full version of the report.

We found concerns with the safe administration and storage of medicines.

Plans were not in place to minimise all risks to people who used the service. For example, where a person was an insulin dependent diabetic or where a person was at risk of choking.

We saw evidence of fire drills that had taken place, however at each one it was recorded that staff were not taking them seriously or ignoring the alarm. No action had been taken regarding the appropriateness of this. No full evacuation or practice simulated evacuation had ever taken place.

Audits were taking place; however, due to a high turnover of manager's in the last year, until now no one had been consistently accountable or had full oversight of the service.

Staff training was up to date, however staff felt the e learning now provided was not substantial enough. Supervisions were now starting to take place but due to changes in management had been lacking so far, this year.

The provider had sought peoples feedback via a questionnaire, however individual views for Willowdene

were not fully provided and not action plan was in place to address any concerns.

Through observation we found there were sufficient staff employed to support people with their assessed needs on the day of inspection. However, relatives and staff said they could be short staffed at times. An anonymous concern was raised prior to the inspection to say staffing levels were dangerously low. The service was using agency staff to cover the nursing unit. They had recently had a high turnover of staff. The registered manager agreed to review staffing levels.

We received mixed views from people on the food provided. There was no information in the satellite kitchens to provide staff with information on each person's dietary needs.

We have made a recommendation stating that all dietary information should be available in the satellite kitchens to reflect people's current needs.

People were supported to continue with their preferred religious needs.

People who lived at the service were safeguarded from abuse. People told us that they felt safe at the service and that they trusted staff. Staff had received training in the safeguarding of vulnerable adults and said they would not hesitate to report concerns.

A number of recruitment checks were carried out before staff were employed to ensure they were suitable to work with vulnerable adults.

The registered manager understood their responsibilities in relation to the DoLS. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; policies and systems in the service supported this practice. Evidence of consent was sought.

Staff demonstrated a person-centred approach to care and they knew people well. However, we found that not all staff knowledge was recorded in people's care files. Care plans had recently moved to an electronic care plan, but not everything had been transferred over, therefore the staff were working with two care plans.

We have made a recommendation about assessing people's needs in a more timely manner.

We saw evidence of activities taking place and people we spoke with enjoyed them.

The service had a complaints policy that was applied if and when issues arose. People and their relatives knew how to raise any issues they had. The service had received five complaints so far this year. Two of these being about staff attitude.

## 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.

We looked at the systems in place for medicines management and found they did not always keep people safe.

Not all risks to people were assessed or plans put in place to minimise the risk.

Staff understood safeguarding issues and felt confident to raise any concerns they had.

The provider carried out pre-employment checks to support them to make safer recruitment decisions.

**Requires Improvement** ●

### Is the service effective?

The service was not effective.

Staff had received the training required, however felt e learning did not support their needs. Supervisions were only just starting to take place again.

People provided mixed reviews about the food provided but they received a choice.

Staff knew their responsibilities under the Mental Capacity Act.

**Requires Improvement** ●

### Is the service caring?

The service was caring.

Staff were kind and compassionate and treated people with dignity and respect.

Staff promoted people's independence.

Staff respected people's wishes and provided care and support in line with those wishes.

**Good** ●

### Is the service responsive?

**Requires Improvement** ●

The service was not always responsive.

Staff demonstrated a person-centred approach to care. However, records did not match staff knowledge.

People were supported to take part in activities they enjoyed.

There were systems in place to manage complaints.

End of life care plans were in place for people.

### **Is the service well-led?**

The service was not well-led.

The quality assurance audits did not highlight the concerns we raised.

Records needed to be improved. More oversight of the service was needed.

The registered manager understood their responsibilities in making notifications to the Commission.

**Requires Improvement** ●

# Willowdene Care Home

## Detailed findings

### Background to this inspection

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

This inspection took place on 22 May 2018 and was unannounced. This meant that the provider and staff did not know we would be visiting.

The inspection team consisted of one adult social care inspector, one pharmacist inspector, a specialist professional advisor (a nurse) and one expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The provider was asked to complete 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 used this to plan the inspection.

Some people living with dementia were not always able to comment directly on their experiences. We therefore, used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people living with dementia.

During the inspection we looked at five care plans, Medicine Administration Records (MARs) and daily records. We also looked at four staff files which included recruitment records. We spoke with the registered manager, the quality assurance manager, one agency nurse, one team leader, four care workers, the activity coordinator and the kitchen assistant. We spoke with nine people who used the service and four visiting relative. We spoke with three visiting health care professionals.

# Is the service safe?

## Our findings

The home had an electronic recording system for the administration of medicines (eMAR) which all units used. Although the system was designed to help the home prevent administration and stock errors we found some of these records to be incorrect. For example, on one unit we found the records of administration for a medicine used to treat constipation were not accurate. This medicine was prescribed to be given once daily but on 11 occasions throughout May 2018 we saw this had been administered twice daily. We also found that over a 21day period in May 2018 it was recorded there was no stock available for a prescribed medicine for indigestion on 31 occasions. On further investigation the person for whom it was prescribed, informed us they had to purchase their own supply due to this. We could find no paperwork to support this and the registered manager was informed on the day of inspection. Therefore, we could not be sure these medicines were being administered safely or accurately.

We looked at records relating to self-administration in the home and found they were not in line with the homes medicines policy. For example, we looked at two people where staff told us they were applying creams or administering medicines themselves; there was no risk assessment in place to support this. Therefore, the provider could not be sure that the individual knew when and how to use their medication appropriately and safely.

Medicines were stored securely. Medicines which required cold storage were kept in fridges within the medicines store rooms. Room and fridge temperatures were not recorded in line with the homes policy on all units; For example, on one unit we found that on 14 occasions over the last month the fridge and room temperatures had not been recorded. We also found that on one unit the fridge had exceeded the recommended temperature on five occasions over the last month with no action taken. Therefore, we could not be sure these medicines were safe to use.

We saw that controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were appropriately stored and signed for when they were administered. However staff were not following their own policy in relation to the frequency of stock checks.

We looked at how the service managed the application of creams to people and found they did not always follow their current medicines policy. We looked at the application records for four people and found two were missing with the rest inaccurate or incomplete. For example, we looked at one record where the incorrect cream had been transcribed from the e-MAR on to the topical medicines paperwork. On further inspection we also found the cream in this person's room to be incorrect. In addition, we were also told that senior care staff signed the MAR to show creams had been applied after confirming with carers, however in the record we looked at the records made by carers did not match. This means we could not be sure topical medicines in the home were being applied as prescribed.

We looked at how the service managed application of patches to people and found they were not following their current medicines policy. We reviewed two records and found both to be incorrect. For example, one person was prescribed a patch for pain relief. This patch required site rotation as per the manufacturer's

instructions, but the home could not provide any record to demonstrate these instructions were being followed.

Medicines to be given when required did not have any protocols in place to guide staff with administration of these medicines. These protocols enable staff to make informed decisions about when and how to administer these medicines. Therefore, we could not be sure staff had sufficient information to administer when required medicines safely.

We looked at the processes for auditing medicines within in the home and found that whilst audits were being carried they were not on a regular basis. For example, the home could only provide us with one audit for one unit this year. Whilst this audit had picked up some issues we found it did not detail the issues we found on inspection. An action plan was in place however this had not yet been fully completed.

In the care plans we reviewed we found that risk assessments were in place for falls. However other risk assessments were not in place. For example, one person was a diabetic but they chose to eat a high amount of sugary foods. There was not risk assessment in place for this, or any guidance for staff to follow if the person suffered a hyperglycaemic episode which can occur when people with diabetes have too much sugar. An advanced nurse practitioner said staff were worried that the person's blood sugar levels were high, which was due to the high sugar intake. However, staff we spoke with said they never check the person's blood sugar levels. We saw the district nurse checked the person's blood sugar levels on their daily visit. The 2015 NICE guidelines recommend that people with type 1 diabetes test their blood glucose at least four times per day, including before each meal and before bed.

Where people were at risk of depression or agitation there was no guidance for staff to support the person or a record of any signs to show a person was becoming depressed or agitated. One person had a risk of choking and received thickened fluids and a fork mashable diet. There was no risk assessment for this. For another person requiring thickened fluids the care plan had no record of the amount of thickener required. There was information in the main kitchen about people's dietary needs. However in the small kitchen on each unit, where staff prepared drinks, information was not always available. There was no information available on the unit for people who live with dementia. Then give the eg of staff not being up-to-date as not on unit all the time.

We saw fire drills were taking place regularly for both day and night staff. However, the records for the drills that had taken place this year all stated that staff did not take the drill seriously, some staff ignored the fire alarm, it was disorganised and staff needed further training. No follow up action had taken place with staff following this, including further fire training or fire drills. We asked if staff had ever practiced a full evacuation and we were told no, we could also see no records of a full evacuation or practice evacuation had ever taken place.

These findings evidenced a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014

All people we spoke with, who used the service said they felt safe with the staff that provided care. Comments included, "Very well looked after and always feel safe with the staff," and "I am here to keep me safe as I wasn't in my own home and it's okay, better than I thought."

One relative we spoke to said, "My [Named person] is cared for well and safe from any harm in the home."

We saw evidence of premises and environmental risk assessments. Fire and general premises risk



assessments had been carried out. Required certificates in areas such as gas safety, electrical testing and hoist maintenance were in place. Records confirmed that monthly checks of emergency lighting and fire alarms were carried out and water temperature checks were taken weekly.

People we spoke with thought more staff were needed. Comments included, "I am not sure there are enough staff to go around, if two staff are attending to a resident then I wait forever to get someone to come and help me." And "I rarely use the buzzer, that's because I have to wait so long I might as well have a go at doing what I want on my own."

The visiting healthcare professionals we spoke with said, "The care home is good but I think they need a few more staff", "When visiting we have noticed that call bells take ages to be answered." And "There has been a lot of changes with staff, lots of inconsistencies and an unsettled team who don't know who to turn to. Nobody knew what they were doing it's been a difficult few months. But things are improving and it feels a lot more positive."

The service had a recent high turnover of staff and new staff were still in the process of their induction. Through observation and looking at rotas there were enough staff on duty to meet the needs of the people. On the day of the inspection there was an agency nurse and three care workers on the nursing unit, two carers on the residential and two cares on the dementia unit with one team leader covering both. Comments from staff stated, "Staffing is ridiculous, we are too busy on computers, showers and baths are not getting done.", "Sometimes there are just two staff on the nursing unit, plus the nurse, but the nurse spends all day doing medicines, so it can be difficult." And "There is no back up to fill shifts, quite often people ring in sick and it drains you it is so bad." We had also received an anonymous concern which said, 'the home was working with 'dangerous staffing levels.' They did not provide any further details to evidence this. Although on the day of the inspection there were enough staff, the registered manager agreed to review staffing levels.

Recruitment procedures were in place to ensure suitable staff were employed. Applicants completed an application form where they set out their experience, skills and employment history. Two references were sought and a Disclosure and Barring Service check was carried out before staff were employed. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and minimise the risk of unsuitable people from working with vulnerable adults.

Staff understood the importance of safeguarding issues and whistleblowing [telling someone] concerns and knew the procedures to follow if they had any concerns.

We saw the premises were clean and tidy, cleaning schedules were in place and records showed these had been followed. Staff told us that there was a plentiful supply of personal protective equipment such as aprons and gloves. We observed staff wearing blue plastic aprons whilst serving meals in the dining room. One person who used the service said, "The home is clean and there are no odours."

## Is the service effective?

### Our findings

People's needs were assessed before they moved to the home, followed by an assessment on admission. The assessments included the person's life skills, potential risks, personal hygiene and as well as the persons likes, dislikes and preferences, finding out their needs and how they wished to be cared for. All this information was incorporated into the person's care plan.

However, we did find that one person who had come to live at the service on the 9 May 2018 had no care plan in place. A staff member was starting it on the evening of the inspection.

There were appropriate systems to support the staff to communicate with each other, including a handover of information at staff change overs so that they always had up to date knowledge of people using the service. The new computer based system red flagged any changes to a person's needs and highlighted that staff were to read about the changes.

One person who used the service thought staff were trained and said, "The staff must be trained to care otherwise they would not work here." We saw certificates to evidence that staff training was up to date. However, no staff had received training in equality and diversity. One staff member said, "We do get training but it's e learning, I don't think you learn anything, we used to get full days face to face training before, this was so much better." Another staff member said, "I prefer classroom based training."

A visiting healthcare professional said, "We have offered to come into the home and give training to staff on diabetes, early warning signs and Sepsis, yet they have not taken us up on this offer." The registered manager confirmed they would contact the healthcare professional to follow this up.

New staff undertook an induction programme, covering the service's policy and procedures and using Care Certificate materials to provide basic training. The Care Certificate is a set of core standards that health and social care workers adhere to in their daily working life. It sets out explicitly the learning outcomes, competences and standards of care that will be expected. New staff also completed shadow shifts [observing] until they and the registered manager felt they were competent to work alone.

We saw that due to the changes in management over the last year that supervision had not taken place as regularly as it should. Supervision is a process, usually a meeting, by which the organisation provides guidance and support to staff. The registered manager had recognised this and started to implement supervisions. The registered manager said, "Supervision's have been sporadic with the changes in management, I have recommenced them so every member of staff will have a supportive supervision. Personal development plans have been implemented by the company and will replace supervisions and appraisals, these are not in place yet but will be once the senior staff have settled into their roles."

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 people lack mental capacity

to make particular decisions, any decisions 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 2005. The application procedures for this in care homes are called Deprivation of Liberty Safeguards (DoLS). We checked that the service was working within the principles of the MCA 2005 and found that they were. There were processes in place to protect the rights of people living at the service. We did see evidence of consent in people's files.

People were supported to access the healthcare services they needed. They had made referrals to other healthcare professionals when needed and the advanced nurse practitioners who visited daily Monday to Friday. People told us they had regular appointments with their GP and other healthcare services, which included visiting opticians and dentists. One person said, "I was poorly a while ago and the doctor was here the same day I only have to ask." A relative we spoke with said, "We were told when [Named person] was unwell, the home has links with excellent GP surgeries that respond quickly."

People were supported to have enough to eat and drink. However, we received a mixed response to what they thought of the food. Comments included, "The food is so so," "We know when the chef is off as the type of food on the menu changes," "If I do not like the food on offer I ask for something different and it is no problem," and "The meals here are nice, I enjoyed my lunch." A relative we spoke with said, "I have eaten at the home and the quality is fine."

We observed mealtimes on all three units. We saw people were offered choice and protective wear for their clothes. However, there were no menus on display on the nursing or residential unit. The registered manager said they have picture menus on order. Picture menus allow people to see as well as read the choice on offer. The Maple unit had a picture board which showed pictures of meals not being offered, this could be confusing for people living with dementia.

For the tea time meal, we saw a jug of 'brown puree' was sent to The Maple unit, we asked what was in the jug and the assistant cook or staff did not know. We saw a label stating Tuesday, steak, potatoes and vegetables, all blended together. We asked if the food that was pureed was always presented together in a jug. Staff said this does not normally happen. We asked if this was prepared on another day due to having a Tuesday label on it, again staff did not know and the assistant cook said, "It was just there to send down." We followed this up with the registered manager who agreed to look into the presentation of meals.

One person on The Maple also needed thickened fluids. A staff member was in the satellite kitchen ready to serve the food. We asked and looked to see if there was information on how the person was to have their drinks presented. There was no information available.

We recommend that due to staff working across all three units, and may not be on one of the units for a couple of months, that all dietary information is available in the satellite kitchens to reflect people's current needs.

We spoke to the assistant cook who was quite knowledgeable about people's dietary needs such as if they needed fortified foods, or their food pureed. We were told that people's cultural diets could be catered for when needed. We asked the assistant cook if people had access to snacks throughout the day. The assistant cook said, "Snacks are offered throughout the day, and these were cakes, biscuits, tea cakes and jam tarts." We observed this taking place.

The assistant cook was unsure if people were consulted regarding menus or asked for feedback after meals. The assistant cook said, "I only ask the downstairs unit but the residents would tell us if they were not happy." The assistant cook could not say why they did not go to the other units.

One person we spoke with felt they could do with further support at meal times. This person had a sensory loss and staff left their plate of food for them and just said, "It's hot." The person said they struggled to manage and worried their clothes would be covered in food. We passed this onto the registered manager who agreed to arrange support for this person during mealtimes.

Systems were in place to ensure people who were identified as being at risk of poor nutrition were supported to maintain their nutritional needs. The Malnutrition Universal Screening Tool (MUST) was used to complete individual risk assessments in relation to assessing the risk of malnutrition and dehydration. MUST is a screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

Improvements were needed to the environment, we saw one toilet and bathroom on the residential side were now used as storage and the sluice was out of order. We were told this had been reported. On the Maple unit one seating area had a telephone with the telephone line trailing around the corner, which could be a safety concern, we passed this onto a member of staff. Also on the Maple unit, a piece of furniture designed for displaying ornaments was used to dump paperwork and looked untidy. Some bedrooms, although not all, had memory boxes outside which helped to assist people to find their room independently.

## Is the service caring?

### Our findings

People who used the service were happy with the care that was provided. Comments included, "The staff are very good, they look after me well", "It's a lovely place and the staff are caring," and "They [staff] are very good."

Through observation we saw staff demonstrated a kind and considerate attitude. When talking to people they bent down so they were at eye level and held their hand or touched the person's arm. We saw that staff and people who used the service were familiar with one another. Families and friends were made to feel welcome and encouraged to visit as and when they wanted.

We asked staff how they supported people's privacy and dignity. Staff explained they always knocked on people's door before entering and we observed this practice. Staff said they kept people covered, as best as possible, when providing personal care. One staff member said, "I keep the curtains closed even if we are on the top floor." Another staff member said, "I lock the door and always talk through what I am doing to make them [person] feel better." We saw some people sat in their rooms with their doors open (their choice) and they explained how they enjoyed the flow of people and the occasional wave and hello as people passed.

People we spoke with said staff treated them respectfully. One person said, "I am never told what to do, I am asked."

Staff said they encouraged people to maintain their independence. Staff we spoke with said, "I will give the person their face cloth and they will use it, I try to get them to do as much as possible." Another staff member said, "We always encourage independence. For example, for one person I encourage them to walk along next to me to keep their mobility."

People said staff offer choice and made sure they were happy with the choices. We saw choices being offered throughout the day for example whether people wanted to join in activities, where a person wanted to sit or what they would like to eat.

The service had an equality and diversity policy in place. We asked staff how they included equality and diversity into their caring role. One staff member we spoke with said, "We treat everyone the same no matter of their specific religion, at present we have no one with a specific cultural need." Another staff member commented, "I have not had training on equality and diversity other than a small amount during induction, but we do support people's religions, we have a priest who comes in to see certain people."

No one at the service was using an advocate. Advocates help to ensure that people's views and preferences are heard. We saw there was information available to people about advocates if they wanted it.

Bedrooms were personalised to suit people's wishes and preferences, for example they displayed family photographs and other personal items which people owned. Bedrooms were considered as people's own personal space where they could spend time alone when they wished or meet in private with family and

friends. One person said, "I like to sleep with a photograph of my husband next to me." We saw this was documented in their care plan.

## Is the service responsive?

### Our findings

Following the admission assessments, a full care plan was developed which centred on the person's needs, wishes and preferences. Care plans had recently moved to an electronic care plan, but not everything had been transferred over, therefore the staff were working with two care plans. The new electronic care plans had very little information and were not personalised. One person who had moved into the service on the 9 May 2018 still did not have a care plan in place, either paper based or electronic. A senior care worker had recognised this and was working on it as we finished the inspection.

We recommend the provider carries out collaboratively an assessment of the needs and preferences for the care and treatment for all people entering the service in a timely manner.

The registered manager explained that due to so many changes in staff along with management the care plans had taken longer to transfer over than originally thought. They said, "I am planning some supporting supervisions to ensure all staff are happy with the electronic care plans or if they need more support."

The paper based care plans were detailed with likes and dislikes, and preferred care needs. For example, one person did not want to be woken up on a morning and liked to stay in bed until they woke up. They also loved watching movies with a box of chocolates beside them and this was fully recorded.

People's life history was all documented which included important events, people important to them, and their work history.

Staff we spoke with could easily explain people's needs, however these were not all recorded. Where people's needs had changed care plans were not always updated. One person's electronic care plan stated how they mobilise, yet a staff member sitting with the inspector quickly noticed that this was incorrect and the person now used a stand aid. We checked the paper based care plan and this had been updated. Staff were not fully completing both care plans whilst they were in the implementation stage.

Staff completed daily records for people's daily needs including fluid charts throughout the day. However, these were not being fully utilised. For example staff were adding in the amount of fluids a person had taken yet there was no target to say how much the person was expected to have. Therefore, staff never knew if they needed more fluids. One person had a fluid target of 1600mls throughout the day and this was documented in their paper based care file but not the computer based care file where fluid was being recorded. The registered manager explained how they were reviewing this to make sure there were learnings from any records kept such as fluid balance charts, making them useful and to make sure people had sufficient hydration.

We found care plans were a work in progress and until the computer based system was fully implemented, using two systems could cause confusion. The registered manager said, "Now we are getting there with staffing we will be making a conscious effort to get the computer system fully complete so we just have one care plan in place."

We asked people and their relatives if they were involved in the planning of their care. People we spoke with were unaware of a care plan. A relative we spoke with said, "As a family we are involved in the care of my relative they would not be able to deal with this on their own."

At the time of our inspection nobody at the service was receiving end of life care but policies and procedures were in place to provide this if needed. Support plans contained records of conversations with people about their end of life wishes where they wished to discuss this.

People were happy with the activities offered. Comments included "My favourite time is when we do music or singing and when someone comes in it always feels special", "I like music and exercise sessions, they keep me young", "I quite like my own company so don't join in the activities but I get one to one support or a paper hour [support with reading the paper] which is great" and "I love the fact that there is things going on and not just the television on all day, I am looking forward to sitting outside in the summer."

One person we spoke with said, "I like spending time sitting at the main entrance so I see the comings and goings, if anything is going on I can join in if I want."

The service employed one activity co-ordinator who worked Monday to Friday. We asked the registered manager why no activities took place on a weekend, they said, "The activity coordinator comes in on a weekend if something special is happening such as the royal wedding. We will look at getting more cover."

The activity coordinator said they enjoyed their role and commented, "I feel it is all about trust, I always smile, look encouraging and look happy for the residents."

On the day of the inspection people were enjoying a singalong and a quiz, we saw people were very enthusiastic and staff joined in too. We also saw that people were attempting to grow their own potatoes.

We asked people and their relatives if they had ever made a complaint and if they knew how to make a complaint. One person said, "If I needed to complain I would ask for a senior as I don't know the manager." A relative we spoke with said, "Complaining to the manager would be a last resort it's better to speak to a carer first."

There was a policy in place for managing complaints. The service had received five complaints since January 2018. Two of these complaints were staff attitude, and the action taken was the manager spoke to the staff member and that staff member apologised. We asked if staff had received training or supervision on customer service. These complaints were from before the new registered manager started working at Willowdene. The registered manager said they would look into them further to make sure appropriate action was taken at the time.

The registered manager came back to us after the inspection and said, "We have looked at the logged complaints since January and can confirm this did not include the same employee or resident. We can confirm that on each occasion the residents have signed to confirm that they are satisfied with the investigation that was carried out and the actions that were taken. I will continue to take concerns or complaints seriously and take appropriate actions and make referrals/notifications where required. If any additional concerns are raised about the staff involved in these incidents or any previous incidents I will also take this into consideration when carrying out any investigation."



## Is the service well-led?

### Our findings

Due to a number of changes in management and staff we found the oversight of the service and the auditing systems were not effective. For example, medicine audits had not highlighted the concerns we found, care plan audits had not highlighted that one person did not have one and records on the computer based system were not updated at the same time as the paper based system and supervisions had not been completed in line with their policy.

Records were not always stored securely. On the Maple unit, past daily notes were stored in an open glass fronted dresser, allowing anyone access. A previous manager had moved the nurses desk into the dining room along with care files and documentation. The now registered manager had recognised this as a breach in confidentiality and was planning to move this.

Records were also untidy with lots of crossings out, care files would have one person's name crossed out with another person's name added. One person's care file said they were in one room number, this was crossed out to another but on visiting the person's room we found they were in a completely different room.

The newly appointed registered manager was working on a number of issues they had found, such as staffing and moving offices. However, until all the correct staff were in place and fully trained, full oversight was lacking. The dining experience needed addressing to make sure all meals were presented correctly and getting all the care plans added to the computer to avoid confusion and potential errors with care.

These findings evidenced a breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014

We asked people and their relatives what they thought of the management of the home. People we spoke with said, "There have been a lot of changes recently and the staff would appreciate some down to earth honesty, at the moment they are very confused." Another person said, "I know there have been many changes and the staff are unhappy, which is a shame as the care is excellent." Relatives we spoke with said, "The manager, who is the manager?" Another visitor said, "I have noticed all the changes and as long as it didn't impact on my friend it was fine."

Visiting healthcare professionals said, "There have been numerous changes within the management team and the staff team. Staff have been inconsistent and unsettled and did not know who to turn to for advice, nobody knows what's going on." And "The care staff appear to know more about the residents than the nurses." However, all professionals we spoke with said they had no concerns with the care and the safety of the people using the service, stating "There have been improvements lately."

We asked staff if they felt supported by the management of the service. Comments included, "I feel supported, we work as a team", "The new manager is nice, they are changing a lot which is hard to get used to", "Things are taking place gradually, the manager is trying to get everyone working together as a good, tight team. The manager listens to us" and "The manager is easy to talk to, if I have a concern I would speak

to them."

People were happy living at the service and comments from them included, "This home is in a beautiful setting and we can go out and enjoy the trees and birds, it would be nice if the staff could enjoy it as well," and "It really is a lovely caring home, just give the carers some more staff so they can have a chat with us sometimes." One staff member said, "We all get on to make it homely, it has good vibes."

The provider had sought peoples feedback via a questionnaire, which did not highlight the responses for Willowdene as it was sent to the whole group of homes in the organisation and the collated format was in percentages. However, it highlighted the percentage of people who were happy or unhappy with the service, but there was not action plan following this and we could not see if anything had been done about the responses. The registered manager stated they were looking at doing more personal surveys that would relate to Willowdene.

Meetings for people who used the service and their relatives took place, however not many were dated so we could not establish how often. The new registered managers name was on the list of people attending so we knew they were recent. Topics discussed at the meetings data protection, the presentation of the service, meals, complaints and activities.

Staff meetings took place regularly and staff said they found them very useful and informative. Topics discussed at these meetings were new staff, training, values, dress code and safety.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC) of important events that happen in the service. The manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	The provider was not doing all that is reasonably possible to mitigate risks. Medicines were not managed safely and records were not completed correctly. Reg 12 (2) (a) (b)
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	The provider did not have systems in place to enable them to identify and assess risks to the health, safety and welfare of people using the service. Records relating to the care and treatment of each person using the service was not always complete, legible, accurate and up to date. Reg 17(2)(b)(c)
Treatment of disease, disorder or injury	