GCH (South) Ltd

Willowmead Care Home

Inspection report

Wickham Bishops Road
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Essex
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Tel: 01245381787

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Willowmead Care Home is a care home in a rural location near Hatfield Peveril which provides accommodation with personal care for up to 60 older people, some of whom may be living with dementia. There were 45 people living at the service. Willowmead Care Home is made up of two units called Hatfield and Wickham which are based in separate houses attached by shared communal gardens. The main offices are based in the larger Hatfield Unit.

People's experience of using this service and what we found
Most people at Willowmead Care Home had some form of dementia and were unable to speak with us. We carried out observations to look at the care they received.

The infection control and prevention measures in place within the service were ineffective. There was an increased risk people could have been exposed to COVID-19. The registered provider had not done all they could have to reduce the risk of transmission or exposure.

The leadership, management and governance arrangements did not always provide assurance the service was well-led. Quality assurance and governance arrangements were not reliable or effective in identifying shortfalls in the service and meeting regulatory requirements.

The registered provider must notify CQC of certain events or occurrences. The registered provider had failed to notify the CQC of seventeen key events or occurrences.

Information relating to risks to people was recorded. Suitable arrangements were in place to ensure the safe management of medicines.

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

Rating at last inspection.
The last rating for this service was Good. (Published 30 April 2019).

Why we inspected
We inspected the service because there had been a recent COVID-19 outbreak and some concerns about the environment people were living in had been raised. We carried out an inspection to examine these risks.

We found infection and prevention control measures were not effective, so we widened the scope of the inspection to a focused inspection which included the key questions of safe and well-led.

We looked at infection prevention and control measures under the 'Safe' key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the

service can respond to coronavirus and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We, therefore, did not inspect them.

Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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

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

We have identified breaches in relation to safe care and treatment relating to infection prevention and control, failing to notify the CQC of events, and good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our well led findings below.

Willowmead Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
This inspection was carried out by one inspector.

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

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke to five members of staff, including the registered manager, and a senior member of staff. Where people at the service were not able to talk with us, or chose not to, we used observation to gather evidence of people's experiences of the service.

We reviewed three people's care records and medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate the evidence found.

Requires Improvement

Is the service safe?

Our findings

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

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

Preventing and controlling infection

- The registered provider had failed to ensure effective prevention and infection control measures procedures were in place to reduce the risk of transmission of COVID-19. For example, the registered provider had not implemented robust processes to ensure the separation of cutlery, cups, plates and the laundry. This meant there was an increased risk of cross-contamination.
- When people had tested positive for COVID-19, the registered provider had failed to implement appropriate measures to zone environmental areas of the service and cohort staff to those areas within the unit.
- On the Hatfield unit, the registered provider had failed to ensure staff undertook and recorded the results of the Lateral Flow Tests (LFT), despite having them available.
- The registered manager had put safety systems in place for when visitors entered the building, but these were not being followed by staff.
- Parts of the Hatfield unit were not consistently clean and hygienic. Some of flooring and furniture would benefit from being replaced to facilitate easier cleaning.
- Some furniture in the Hatfield unit had been removed to support social distancing but it meant other areas of the service were cluttered and this meant effective cleaning could not take place. After the inspection this had been quickly addressed.
- There was a lack of ventilation in all areas of the building.
- Staff told us they had been given Infection Prevention Control (IPC) training, but not COVID-19.
- Cleaning schedules could not be easily located to evidence records and checks of compliance with the cleaning schedule, and some areas of the service needed cleaning.
- We were not assured that the provider was preventing visitors from catching and spreading infections.
- We were not assured that the provider was accessing testing for people using the service and staff.
- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

As the registered provider had failed to ensure staff followed robust systems to mitigate risks for people's wellbeing and safety. This was a breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

- We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider's infection prevention and control policy was up to date.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong; Assessing risk, safety monitoring and management
● When a safeguarding incident had occurred, the registered provider had not considered how learning could be used to improve the service people received. For example, one safeguard was being investigated by the local authority relating to staff not being able to identify when people needed medical care. The registered manager had not used this information to review staff practice and ensure they were carrying out the care in line with people's records and the company's policies and procedures.
● The registered manager had failed to carry out individual risk assessments for people who used the service relating to COVID-19. This meant people and staff who may be at increased risk of contracting COVID - 19, for example, those with underlying health conditions, had not been assessed.
● Risks to people had been identified and records were in place to mitigate the potential risk of harm for people using the service. For example, a range of risk assessments was in place relating to pressure care, bed rails, nutrition and hydration, moving and handling, and diabetes.
● Staff had been given safeguarding training.

Using medicines safely
● Suitable arrangements were in place to ensure the proper and safe management of medicines.
● The medication administration records (MARs) we inspected had no gaps and indicated people received their medicine at the right time and in the right way.
● The registered manager carried out audits to check people received their medicine correctly.
● Staff told us they had been given medicine training.

Staffing and recruitment
● Suitable arrangements were in place to ensure staff employed had had the appropriate checks undertaken and were suitable to work with vulnerable people.
● The registered manager told us several agency staff worked at the service to provide cover if staff were on holiday or off sick.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Whilst the registered provider had policies and procedures in place to deal with the pandemic, they had failed to implement these consistently and in a way that ensured safe systems were in place to mitigate the risk of transmission, to people, staff or visitor's.
- The registered manager had not ensured staff had taken Lateral Flow Tests (LFT) and had failed to record when this had taken place.
- The registered manager said that he had found obtaining information from staff after they had taken a COVID-19 test difficult.
- The registered manager had failed to ensure staff follow the correct measures to prevent relatives & friends, professionals and others visiting from spreading infection at the entrance, when entering the premises.
- The registered manager had failed to ensure that food being transported, was done in a way which minimised transmission of infection. For example, food was transported to the Wickham unit using a trolley, which had been taken though communal areas, where people were self isolating, rather than being taken out the back from the kitchen. After the inspection, the registered manager confirmed that changes had been made to the way people's food was transported.
- The registered manager was unable to provide accurate information relating to how many people were COVID-19 positive.

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

- The arrangements to assess and monitor the service were not effective. This meant there were missed opportunities to mitigate risks and to make sure people living at the service remained safe.
- The provider's oversight of the service was not effective. The area manager completed quality checks of the service. These audits had identified some of the issues we found, but action had not been taken to address the issues. After the inspection, the registered manager sent us an action plan explaining what immediate improvements were going to be made to the service.

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

● The registered manager carried out a range of audits, but these had failed to address the issues we found.
● The service was not consistently well led. The service comprised of two units, Wickham and Hatfield. Wickham unit had a senior member of staff who had a strong emphasis on trying to ensure the spread of infection was prevented and managed. Subsequently, at the time of the inspection no people had tested positive for COVID-19.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Staff meetings were held to give the management team and staff the opportunity to express their views and opinions on the day-to-day running of the service. There were no action plans completed to evidence how issues raised and discussed were to be addressed, dates to be achieved and if these had been resolved or remained outstanding.
● Following the inspection, we asked the registered manager to provide evidence of the arrangements in place for gathering people's views of the service. No information was provided to demonstrate a formal system was in place.
● The registered manager had not obtained assurances from the agency that staff would not work in other locations, to reduce the risk of spreading infection.

Effective systems were not in place to monitor the service and ensure compliance with regulatory requirements. This was a breach of Regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

● The registered provider had failed in their duty to have appropriate oversight of the service. The registered manager had failed to notify us of two safeguarding concerns and fifteen deaths. Because they had failed in their duty, this was a breach of the Care Quality Commission (Registration) Regulations 2009: Regulation 18 Notification of other incidents.

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 18 Registration Regulations 2009 Notifications of other incidents Registered persons must submit information to CQC about a range of event or occurrences. Because the registered manager had failed to notify us of two safeguarding concerns, and fifteen deaths.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure that they robust systems were in place to mitigate risks for people's wellbeing and safety.

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	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to monitor the service and ensure compliance with regulatory requirements.

The enforcement action we took:

Issue Warning Notice.