Care Quality Commission

Young@heart (The Willows) Care Home Ltd

The Willows Care 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?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

We carried out an unannounced comprehensive inspection of this service on 1 and 3 December 2014.

Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the following breaches:

- Consent to care and treatment.
- Care and welfare of people who use services.
- Safeguarding people who use services from abuse.
- Management of medicines.
- Incidents and accidents.

Warning Notices were issued in relation to

- Assessing and monitoring the quality of service provision.
- Records.

We undertook this focussed inspection on the 30 April & 8 May 2015 to check that they had followed their plan and met their legal requirements. We also inspected in

Summary of findings

relation to concerns raised since the last inspection. These concerns related to inadequate staffing and lack of training specific to moving and handling and management of medicines.

This report only covers our findings in relation to the breaches and concerns raised.

At this inspection we found action had been taken to ensure people were safeguarded against abuse and mental capacity assessments had been completed in accordance with The Mental Capacity Act (2005). There were still concerns relating to records as we found they were still inaccurate and there was a lack of robust quality audits, and staff training was not up to date. We had received all notifications as required by law in relation to incidents and safeguarding's. We are taking action against the provider regarding our concerns.

The Willows Care Home is registered to provide personal care and accommodation for up to 27 people. On the day of our visit there were 22 people living at the home.

At our last inspection we asked the provider to take action and ensure the service had a registered manager in post. At this inspection there was not a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manager 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.

People continued to be at risk of receiving inadequate care because the provider's actions did not sufficiently address the on-going failings. This was despite the support provided by the home's management team. There has been on-going evidence of inability of the provider to sustain full compliance since 01 October 2010. We have made these failings clear to the provider and they have had sufficient time to address them. Our findings do not provide us with any confidence in the provider's ability to bring about lasting compliance with the requirements of the regulations. We are taking further action in relation to this provider and will report on this when it is completed

The overall rating for this provider is 'Inadequate'.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

We found that this service was still not safe.

People were not protected against the risk of receiving medicines in a safe and proper way due to staff not being competent or trained.

Records had improved but were not always accurate and timely.

New staff had received appropriate checks before they started with the service.

We could not improve the rating for safe from inadequate because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

Is the service effective?

Requires improvement

We found that some action had been taken but that the service was still not always effective.

There were still some inaccuracies with assessments undertaken for those who lacked capacity. One person who required a best interest decision did not have one in place in relation to a specific care need.

There were training shortfalls for new and existing staff. Some staff had not received the training required to undertake their role skilfully and knowledgeably.

We could not improve the rating for effective from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

Is the service caring?

Good

Is the service responsive?

Requires improvement

We found that some action have been taken to make sure the service was responsive.

All complaints were being logged and the manager had recorded actions for most of the outcomes. Where there was no recorded outcome for one of the complaints, they were able to confirm the actions they had taken.

Reviews had been carried out every month on each person's support needs and risks to their health and welfare but these were not robust and did not always identify changes that had occurred.

We could not improve the rating for responsive from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

Summary of findings

Is the service well-led?

Inadequate 

We found the service was not well led.

Audits of care plans and staff files were failing to identify wide spread areas of concern relating to incidents and accidents, staff training, poor records and staff conduct.

The service did not have a registered manager in post. We are taking action against the provider.

We could not improve the rating for well-led from inadequate because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

The Willows Care Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of this service on the 30 April & 8 May 2015.

This inspection was done to check that improvements to meet legal requirements planned by the provider after our 1 and 3 December 2014 inspection had been made.

We inspected the service against four of the five questions we ask about services: is the service safe, is the service effective, is the service responsive and is the service well lead. This is because the service was not meeting some legal requirements.

The inspection was undertaken by two inspectors and a specialist advisor on the first day and the two inspectors on the second day. A specialist advisor is a person who has specific expertise. The advisor used had specialist knowledge relating to mental capacity and those who have dementia. During our inspection we spoke with two people, one visitor, two visiting professionals, five members of staff, the manager, the provider and the regional support manager. We looked at four care plans, a sample of medication administration records, 10 personnel files, quality auditing processes, policies and procedures, incidents and accidents and reviewed four daily records of care.

Inadequate

Is the service safe?

Our findings

At our last inspection on the 1 and 3 December 2014 we found that people were at risk due to medicines being left unattended in a communal area which placed people at risk of harm. Since that inspection we received information of concern that staff had not received training in relation to the administration of medicines.

On our follow up inspection which was concluded on 8 May 2015, we found people were still at risk of receiving medicines in an unsafe manner. This was due to staff not being trained or competent to administer medication. The manager initially confirmed staff had received training in the safe administration of medicines and the staff member that morning had received training. We found there was only one member of staff who had received medication training in line with the provider's medication policy and who was safe to administer people's medication. The staff member that day had not received the required training. The manager confirmed they had completed the training matrix at the end of March 2015. It clearly identified that only one member of staff had received training in administering medicines. Medicines training had been planned for February 2015 but the manager confirmed that training sessions had not taken place. The manager said they had liaised with a training company to cover a range of training, but at the time of this inspection the manager could not confirm the training dates.

The manager said they had completed three staff competencies in relation to safe administration of medication. We asked to see copies of these, but the manager could not provide them. We found there had been five incidents relating to medication issues and poor staff practice. For example staff failing to check in received medicines, not reading dosage instructions and administering incorrect doses and failing to take appropriate action when medication was refused. We raised our concerns about the incidents, and lack of training for staff on the first day of the inspection on 30 April 2015. When we returned on the second day of inspection, the manager had arranged medication training. We found eight staff had received medication training. Confirmation was provided after the inspection which confirmed seven staff had completed a competency check and had received their certificates. This meant people at the time of our inspection people were at risk of receiving care and treatment that was unsafe in relation to their medication needs, but the provider/manager took urgent action to ensure staff received training and were competent in administering medicines.

At our last inspection we found that not all risks to people using the service were appropriately assessed and reviewed. Care records failed to identify specific support in relation to moving and handling equipment and the person's needs. During this inspection we reviewed four care plans relating to the risk of falling, moving and handling and unpredictable behaviour. Improvements had been made as three care plans contained information that was up to date and accurate. One care plan however did not accurately reflect new equipment and support required. For example a new nursing bed had recently been provided. This was a change to sleeping in a chair. This bed allowed staff to adjust the position and height and prevent the person developing pressure sores. The moving and handling risk assessment did not explain how staff should provide support when transferring the person from this bed. It only confirmed previous support from the chair. We spoke with staff who confirmed the person sleeps in a bed. They showed us how they safely use this equipment and the assistant they provide. This support was not confirmed in the person's moving and handling risk assessment. This meant although staff knew how to support this person and undertook this safely the equipment and assistance required was not up to date in the persons moving and handling risk assessment. This is important as it give staff clear guidelines on how to support someone and with what equipment. The out of date risk assessment had not been picked up through the monthly evaluation and audits of the persons care plan. The manager felt certain a new risk assessment had been completed but they were unable to find this on the day of the inspection.

At our last inspection we found care records did not contain up to date information in relation to people's care and welfare. We also found records relating to injuries and body maps for people were incomplete and inaccurate along with fluid and repositioning charts. At this inspection we found the service had made some improvements but there were still some concerns relating to records being accurate and a true reflection of care and treatment provided at that time. This related to four separate records including food and fluid charts, and repositioning charts which had not been completed.

Inadequate

Is the service safe?

We observed throughout the second day of our inspection the recording of two people's food and fluid charts along with the care they received. We found for both people these records had been completed inconsistently. For example there were inconsistent and inaccurate recording of food and fluid intake. We found records that were completed by care staff did not reflect the actual amount the person had eaten or drank. When we spoke to a member of staff about the inaccurate recording, they amended the record. This meant people were at risk of poor care as records did not reflect the person's true intake We fed this poor practice back to the manager who will monitor and address the recording of these records.

People who were at risk of developing pressure sores had care plans in place to ensure their position was regularly changed. Repositioning charts and observations confirmed care had been provided but it did not always accurately reflect the required hourly position changes. For example, one person's care plan for pressure sores stated their position should be changed four hourly, but their chart showed three hourly. Care had been provided every three hours. We reviewed another person's positioning chart and found it did not give clear instruction as to how many times this person required repositioning. Their care plan confirmed three hourly but this had only been written on one repositioning chart out of the 12. This meant the other 11 charts did not contain the frequency, there was a risk that this person would not be repositioned as needed. This meant people were at risk of not receiving appropriate care and treatment due to inconstant and inaccurate records.

We found that the registered provider had not protected people against the risk of poor inaccurate records. This was a breach of regulation 17(2)(c) The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Records relating to people's care and welfare had improved. We found people who were unable to give their life history, a book had been sent to relatives and significant others. This book contained Information individual to the person. This was reflected in the care plan. This meant care plans were individual to the person identifying information that was important to that person such as their like for cats and seeing family and visitors. This is important as information such as this supports staff to give personalised care that reflects people's likes and dislikes. This is especially important when supporting someone with dementia who might not be able to express these wishes.

At our last inspection we found not all risks relating to the environment had been identified and recorded with an appropriate supporting risk assessment. For example we found an uneven floor in the lounge and gates across the stairs. This meant negotiating around the environment could be difficult for those with visual and mobility impairments. At this inspection we found both these risks had been removed from the environment. We saw the floor area in the lounge had been repaired and was no longer a trip hazard and both gates to the stairs had been removed. This meant people were no longer at risk of environmental hazards identified on our last inspection. We will review environmental risks in greater detail at our next inspection.

At our last inspection we found that incidents relating to safeguarding concerns had not been actioned as required to ensure people were safe from abuse. At this follow up inspection all concerns relating to people being safe had appropriate referrals made to the safeguarding authority and the Care Quality Commission (CQC). Staff were knowledgeable about their role in protecting people from abuse and all were able to describe the reporting process. Staff told us "I would have no hesitation in speaking up; I've done it before and I would do it again if I was worried about anyone or anything". Another member of staff told us "I won't stand for anything bad; I have no problem reporting concerns to the manager".

Due to information we had received since the last inspection in December 2014, we focussed on reviewing the staffing levels in the home and observing if people's needs had been met. During our inspection we found call bells were answered promptly and people's needs were being met in a timely way. The manager confirmed they review staffing levels and make adjustments as required. They currently had an extra member of staff who was ensuring people's rooms were tidy. This meant on the day of our inspection, the service had adequate levels of staff on duty to meet people's needs.

Information of concern had also been received regarding recruitment practices. Out of the nine new starters, eight files contained a current disclosure and barring service (DBS) check prior to the commencement of their employment. One file did not contain confirmation of a

Inadequate

Is the service safe?

DBS check. Action to address this missing DBS had been taken by the manager since we brought it to their attention in December 2014. This meant the provider and manager had ensured staff were of good character before they commenced their employment. All other checks such as ID and reference checks had been undertaken prior to commencing employment.

Requires improvement

Is the service effective?

Our findings

At our last inspection on the 1 and 3 December 2014 we found that the principles of The Mental Capacity Act 2005 were not being applied correctly and appropriately. For example one person had capacity to make their own decisions yet a capacity assessment had been completed. Another person had an inaccurate assessment relating to their communication abilities and best interest decisions were not being documented.

At this inspection we found some improvements but there was still inconsistent practice and one error relating to inaccurate records. We reviewed three peoples care plans in relation to their mental capacity assessments and best interest decisions. Two of these care plans contained inaccurate records and missing best interest decisions. For example the first care plan had no best interest paperwork present for a specific care decision. This person who did not have capacity had various completed best interest paperwork relating to personal care, nutrition, continence care and dressing. But there was no best interest paperwork in place for the person to be cared for in bed rather than in a chair, which was their choice. The manager confirmed a meeting had taken place with the person's next of kin but there was no best interest decision paperwork in place and they were not aware that one should be.

The second care plan had a conflicting mental capacity assessment in place. Their mental capacity assessment was crossed to confirm the person was unable to make decisions in relation to personal care, nutrition and dressing. The comments and notes beside these decisions contradicted this by saying, yes the person likes to choose their clothes and walk around the home. With staff support they were also able to make decisions about personal care, meals and drinks. We observed this person undertake a personal care activity independently. This meant the persons records relating to their mental capacity were inaccurate rather than the Mental Capacity Act 2005 not being followed.

We had received information of concern since the last inspection which related to inadequate staff training. At our last inspection there were some areas of concern which related to new staff induction, training and support for staff. We saw there was a service training plan in place that confirmed training staff would receive in January, February and March 2015. At this inspection we reviewed the training staff had received and found only nine staff had attended safeguarding training, seven record keeping and seven moving and handling out of twenty four staff. There were significant gaps in training where staff had not received training in relation to their role. For example twelve staff had no date recorded for attended safeguarding training, twenty three staff had no recorded date for attending Mental Capacity Act training, eight staff had no date recorded for moving and handling training and thirteen other staff required training in record keeping. The manager confirmed the training matrix was up to date and they were looking to book training over the coming months. At the time of the inspection we were told no training relating to these shortfalls had been booked. This meant people could be at risk of receiving care and support due to the lack of training received by staff.

We looked at staff files for eight workers who had commenced work since December 2014. These contained a completed induction programme. We reviewed what training these staff had undertaken and found most of these staff had not received the necessary training to enable them to undertake their role safely. For example six staff required training in moving and handling and record keeping and five in safeguarding adults. One new member of staff responsible for the administration of medication had not received any training since their start date in December 2014. We spoke with one new member of staff who had recently undertaken their induction training. They told us "I got told about fire exits, call bells etc on my first day, but other than that I have received no training since starting here". The manager confirmed they needed to book training for all staff and they were using the training matrix to identify this.

We found that the registered provider was not ensuring staff were competent, trained and skilled to enable them to carry out their duties. This was a breach of regulation 18(1)(2)(a) The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Good

Is the service caring?

Our findings

Requires improvement

Is the service responsive?

Our findings

At our last inspection on the 1 and 3 December 2014 we found that the service was not analysing complaints or ensuring feedback was taken forward to use complaints as a learning opportunity and improve care experience. At this inspection we found four complaints had been received and recorded. All but one had a clear log of action taken. We discussed this with the manager. They confirmed what action they had taken in relation to these concerns raised and that the complaint was now closed. This meant all complaints were being logged and appropriate actions taken. We have reminded the provider to ensure all complaints have a clear log of actions taken. We will continue to monitor complaints and will review this at our next inspection.

At our last inspection we found evaluations of care plans had not highlighted areas such as changes to people's physical and verbal aggression. This meant care plans were not accurate and the evaluation process had failed to identify concerns. At this inspection we reviewed two care plans relating to changes in the persons behaviour and mobility. We found one care plan contained all changes relating to the persons behaviour. Support plans had been amended, dependency scores and new guidelines for staff to follow had been implemented. The monthly evaluation of these plans had identified changes. The second person's care plan failed to record a new piece of equipment in place. The monthly evaluation of their moving and handling risk assessment also failed to identify this piece of equipment. The record showed each month an evaluation of the moving and handling section of the care plan had been completed but there was no identified change recorded. This meant the evaluation process still failed to identify changes to people's needs which required a change to their care planned needs. We fed this back to the manager and provider.

Inadequate

Is the service well-led?

Our findings

At our last inspection on the 1 and 3 December 2014 we found that the service had not ensured all incidents and accidents were logged and analysed. For example some injuries documented in people's care plans, daily records and body map's these had not been recorded as an injury. Since this inspection the regional manager took responsibility for auditing care plans and staff files. At this inspection we found missing incidents that had not been logged or identified through robust audits with clear action plans. This meant people could be at risk due to the service failing to identify missing incidents and accidents.

For example we found a total of eight missing incident between 7 February 2015 to 30 April 2015. Forms which related to two falls, five medication issues and one verbal altercation. One person's daily care records confirmed the person had been verbally aggressive towards another person and had fallen, both on the same day. We reviewed the overall incident logs recorded for that day. We found none had been logged for either of these incidents. This meant that although staff knew how to report incidents and accidents, this did not happen in practice. We reviewed the two audits completed on this persons care plan. Both audits were not dated to show when they had been completed and they failed to identify or evaluate the incidents that had occurred. We asked the manager for an overview of all care plans audited and actions required. They were unable to provide us with this information. On the second day of our visit the provider confirmed the regional manager had completed a comprehensive audit of all the services care plans. We asked for a copy of this to be sent to us. This audit had failed to highlight in this persons' care plan the recorded information which should have been logged following these two separate incidents.

There were five missing incident forms which related to administration of medication. The manager confirmed there was no current system for recording incidents of this nature. We reviewed the service's medication policy. It contained a form that should be completed for every error that occurred in the administration of medication. The manager confirmed none of these forms had been completed.

We reviewed audits completed on staff files as we were aware that some staff had been disciplined following medication errors. We found no audits had been completed on the files of these staff following the identification of the medication errors. Out of the five incidents relating to these errors, two had indicated these had been the result of poor staff conduct. Although files contained information relating to the concerns and actions taken, there had been no consideration by the provider to report these to the Disclosure and Barring service (DBS). Due to the incidents relating to poor staff practice. We reviewed what actions the manager had taken to prevent this from happening again. They were unable to confirm any action had been taken to ensure incidents of this nature did not happen again.

We found that the registered provider had not protected people by ensuring robust audits identified areas of concern and had clear associated action plans. This was a breach of regulation 17(1)(2)(b) The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At our last inspection we found that the service had not ensured all incidents and accidents were reported without delay to CQC. At this inspection we found all safeguarding concerns and significant incidents were being reported as a statutory notification. We will continue to monitor this.

At our last inspection the home did not have a registered manager in post. The previous registered manager had left in July 2014 since then the service has been without a registered manager. We informed the provider in December 2014 that they needed to take immediate action to rectify this. At the time of this inspection there was a permanent manager in post but no registered manager. We have informed the provider in June 2015 that they need to take immediate action we are monitoring the service relating to this and other areas of concern.

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 This was a breach of regulation 17(2)(c) The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. We found that the registered provider had not protected people against the risk of inaccurate and contemporaneous records due to records not reflecting the care given. This was a breach of regulation 17(1)(2)(b) The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. We found that the registered provider had not protected people by ensuring robust systems were in place to ensure all incidents and accidents were being logged and analysed for trends.

The enforcement action we took:
We have imposed a restricted condition. The Registered Provider must not admit any new service users for the purposes of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing This was a breach of regulation 18(1)(2)(a) The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. We found that the registered provider had not protected people by ensuring staff were suitability competent, trained and skilled to enable them to carry out their duties.

The enforcement action we took:
We have imposed a restricted condition. The Registered Provider must not admit any new service users for the purposes of the regulated activity.