

Premier Nursing Homes Limited

Willowdene Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Good ●

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

Willowdene Care Home provides nursing care for older people, some of whom are living with dementia. It is registered to provide care for 52 people. At the time of our visit there were 39 people living at the home. This inspection took place on 31 March and 1 April 2016 and was unannounced on the first day. This meant the provider did not know we would be visiting.

We last inspected the service in August 2015. We found there was not enough staff deployed to ensure people's needs were met. The provider did not ensure staff received appropriate training and development to enable them to carry out the duties they are employed to perform. People did not receive the appropriate support and encouragement to eat and drink. Staff did not treat people with dignity and respect at all times. The provider did not have effective quality assurance processes to monitor the quality and safety of the service provided and to ensure that people received appropriate care and support.

No registered manager was in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 home had recently been decorated and had a fresh clean look and people's rooms were homely and personalised.

The provider carried out regular health and safety checks including checks of gas safety, electrical safety, electrical appliances, fire safety and water safety.

Recruitment checks were conducted prior to an applicant's start of employment. However recruitment records were not always updated to reflect this.

Risk assessments were completed individually for people using the service based upon their needs.

Medicines were managed safely. The provider had systems in place for the receipt, administration and disposal of medicines.

Accidents and incidents were recorded and collated however no analysis was conducted to identify any patterns or trends.

During the short period the new manager had been in place staff training had raised from 62% to 86% completed and a supervision and appraisals programme had been introduced.

At mealtimes staff were attentive and responded quickly to people's needs. They encouraged people to be as independent as possible and were happy to support when they were required. However we did observe

people on a specialist diet were made to wait for their meal.

Each person had an individual emergency evacuation plan detailing how to support them in the event of an emergency.

Staffing levels had been increased since our last inspection. The manager regularly reviewed staffing levels taking into account people's needs.

The home offered a range of activities and encouraged involvement with families. Although we found no specific activities were available for people living with dementia.

The provider did not ensure people's authorisations for Deprivation of Liberty Safeguards (DoLS) were monitored and we noted appropriate requests were not always made in a timely manner.

Staff demonstrated a general knowledge about the people they supported and their families.

The home ensured people received care and support from healthcare professionals including social workers, community psychiatric nurses, occupational therapists, and GPs.

Where people had no family or personal representative we saw the home provided information about advocacy services.

Staff told us they enjoyed working at Willowdene Care Home and they felt supported by the manager.

Feedback was encouraged from people and the manager acted on the comments received to continually improve the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was not always safe.

Recruitment checks were carried out prior to staff beginning work. However records did not always reflect this.

Systems were in place to manage medicines in a safe way and people were supported to take their medicines.

Safeguarding concerns were investigated and referred to the local authority.

Is the service effective?

Requires Improvement ●

The service was not always effective.

The provider did not always act in accordance with the Deprivation of Liberty Safeguards code of practice.

The provider had developed a training programme to ensure staff had the appropriate skills to support people.

Staff supported people to eat and drink and promoted a balanced diet.

Is the service caring?

Good ●

The service was caring.

Relatives told us the staff were kind, considerate and caring.

Staff were respectful when providing care and support to people.

People were encouraged to be as independent as possible.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

A range of activities were available however there were no activities specifically designed to meet the needs of people living with dementia.

People's care plans lacked information about the person, their life history and family structure. People's support plans were regularly reviewed to ensure they were meeting people's needs.

The provider had a complaints system in place and issues were dealt with appropriately.

Is the service well-led?

The service was not always well led.

The provider had introduced a quality assurance processes to monitor the quality and safety of the service provided. Although the evidence of this monitoring was not consistently recorded.

No registered manager was in place at the time of our inspection. The manager had started their application to become a registered manager.

The manager involved people, relatives and staff with decisions regarding Willowdene.

The manager was approachable and provided strong leadership and direction for staff.

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 over two days. On the first day 31 March 2016 the visit was unannounced which meant the provider and staff did not know we were coming. The provider and staff were advised we were returning on 1 April 2016. The manager was on annual leave on both days we visited the service. They attended for a couple of hours on the first day and over the two days we were supported by a peripatetic manager sent to assist by the registered provider. The inspection team consisted of one adult social care inspector and a specialist advisor in nursing care.

Prior to the inspection we reviewed information we held about the home, 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. We also contacted the local authority commissioners for the service and the local authority safeguarding team, the local Healthwatch and the clinical commissioning group (CCG). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. None of these organisations raised any current concerns.

During this inspection we spoke to four people who lived at Willowdene Care Home, two family members, the manager, the peripatetic manager, two nurses, administrator, maintenance lead, painter, six care assistants, three ancillary staff and two kitchen staff.

We looked at five people's care records and ten staff files including recruitment information. We reviewed medicine records and supervision and training logs as well as records relating to the management of the service.

We carried out an observation using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We undertook general observations of how staff interacted with people as they went about their work.

We looked around the home, visited people's bedrooms with their permission and spent time with people in the communal areas.

Is the service safe?

Our findings

We examined nine staff recruitment files. We found each record held an application form, interview record, two completed reference checks and Disclosure and Barring Service (DBS) checks. We noted two files did not have a date for a Disclosure and Barring Service (DBS) completed check and reference number. In another we could not see a record that a Nursing Midwifery Council (NMC) pin number had been checked against the NMC register to ensure they were safe to practice and held a valid registration. DBS checks help employers make safer decisions and help to prevent unsuitable people from working with vulnerable adults. We discussed the matter with manager who was able to produce confirmation that the DBS checks and NMC registration were in place.

We reviewed the accident and incident records. We saw information related to individuals, including types of accidents, time occurred and injury. We noted records were collated and the numbers and type of injury recorded monthly. However we did not see any evaluation to identify any trends or contributory factors which may require investigation. We identified two accidents relating to moving and handling. The manager told us, "We looked in to these accidents and implemented training. I just need to complete the full trend analysis document."

Relatives we spoke with told us their family members were safe at Willowdene. One relative told us, "Without a doubt I know [Person] is safe here." Another said, "I know I can leave and [Person] is safe."

The home was clean and areas had recently been redecorated. The large wooden nursing station had been removed and replaced with additional seating which relatives and people seemed to enjoy using. We saw monthly checks were conducted in such areas as window restrictors, Co2 detectors, water temperatures, emergency bag and wheelchairs. All records relating to the maintenance and safety of the building and equipment were up to date and monitored. The maintenance person was passionate about the home and the people living at Willowdene. They told us, "This is people's home I make sure everything is up to date. Things have to be right to make sure people are safe."

Staff we spoke to had an understanding of safeguarding and were able to describe the types of abuse to look out for. 92% of staff had completed safeguarding training. Staff were clear on what action to take if they witnessed any situations which concerned them. One care worker told us, "I would speak to the nurse or the manager." We saw the manager made alerts to the local authority and investigated all concerns. Although lessons learnt from individual safeguardings were not collated to identify if trends or patterns needed further investigation.

Relatives we spoke with told us they felt there were enough staff to meet people's needs. One relative said, "[Person] has never had to wait." During our two day inspection we did not observe people being left for long periods. Staff were responsive to call bells and worked together well to ensure people had support readily available if required.

We examined staffing rotas for the two previous months and the current month. On the ground floor the day

shift consisted of one registered nurse and four care workers with one care worker assigned to deliver 1:1 care to one person. One registered nurse and four care workers were deployed on the first floor. At night one registered nurse and five care workers were on duty across the whole service. The manager told us the staffing levels were dependent on the needs of the people using the service. They told us, "We have increased staffing and ancillary staff are supporting people at mealtimes."

Risk assessments were completed individually for people using the service based upon their needs. We saw people had risk assessments for bed rails, falls, and personal hygiene. The provider also had general risk assessments relating to the environment. We saw reviews were carried out monthly; this meant staff had current accurate information on how to keep people safe.

We asked the manager what emergency evacuation procedures were in place for people who used the service. They told us an emergency bag was available in the entrance of the home. The bag contained a high visibility jacket, emergency blankets, a walkie-talkie and people's and staff's details. Each person had a personal emergency evacuation plan (PEEP) which detailed how to support the person in the event of an emergency. The home did not have a business continuity plan to show how the service would continue to care safely for people in the event of an emergency. The manager told us the provider was in the process of producing one.

We found medicines were managed safely. Medicines were stored within a clinical room on each floor. The rooms were spacious, clean and tidy. All medicines were secure in locked cupboards and the only key holders were the trained nurses working and in charge of the floor that day. The receipt of keys was signed on the handover sheet each day. A record was kept daily of the treatment rooms and fridge temperatures and both were recorded and found to be correct.

Medicines were supplied in blister packs which were in 28 day supply for each person which were placed on racks and colour coded. The medicines administration records (MARs) we viewed showed no gaps or discrepancies. A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. All signatures were in place and the appropriate code used and information documented on the back of the MAR sheet to explain the code, for example if a person refused a medicine.

The controlled drugs (CD) cupboard and extra medicines were in a locked cupboard. The controlled drugs were correct and a record showed these were checked when given and also as a weekly check. We noted the index held the information of people who no longer lived at Willowdene. We discussed this with the manager who advised a new CD book had been purchased and records were to be transferred.

Is the service effective?

Our findings

We last inspected the home in August 2015. We asked the provider to take action to make improvements in relation to the training, supervisions and appraisals that were available to staff. The provider submitted an action plan in October 2015.

The provider's action plan reported, 'All training to achieve up to 90%' by 30 December 2015. The manager told us, "We are at 86% staff have really worked hard to complete their training. We were at 62% in October." The provider had achieved its aimed target of 90% in the following subjects infection control, moving and handling and SOVA. However 77% of staff had completed fire practical and 71% dementia awareness. The provider had nine mandatory training subjects and had also commenced training in areas such as pressure ulcer presentation, falls awareness and record keeping.

The manager advised supervisions were conducted six times a year with an annual appraisal. The supervisions matrix indicated 11 staff had not received a supervision whilst others had received two. The manager advised this was because some supervisions required follow ups. The manager told us, "I wanted time to get to know staff, I now know who to allocate staff to."

We saw out of 53 staff only 10 staff had not received an appraisal since we last inspection in August 2015. The manager told us, "I felt I needed six months to get to know the home and staff and the way they worked." We saw the manager had created a matrix for supervisions and appraisals for the year ahead.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found where people had previously had a DoLS in place requests for a new application had not been made prior to the expiry date. For example, we saw two people's DoLS had expired in October 2015 and one in February 2016. Requests for new authorisations were made in January and February 2016. This meant that for the period of four months people were deprived of their liberty without the necessary authorisations.

On reviewing the DoLS folder we saw hand written notes on previous requests reporting requests had been

made for new authorisations however no completed documentation was present. The manager told us, "I have completed all the required documentation." We asked the manager if they had a system for monitoring the authorisation of DoLS. They advised they would implement one. Following the inspection the manager provided copies of the authorisations made in 2016.

We observed one person had a safety gate positioned across the doorway of their bedroom. Within the person's care plan they had been assessed as lacking capacity. However, no evidence was present indicating best interest discussions had taken place to ensure the restriction was in the best interests of the person. There was also no discussion or exploration the safety gate would be the least restrictive option to meet the needs of this individual.

We examined five care records and within each we saw evidence of MCA assessments being carried out for people who lacked capacity to make decisions for themselves. Staff we spoke with were able to discuss how to support people to make choices and decisions. Records confirmed staff had completed MCA training.

Relatives and people we spoke to told us they enjoyed the meals at Willowdene Care Home. One relative told us, "The meals are all made fresh, all homemade in the kitchen." One person said, "The food is lovely." Another told us, "The food is really good and we have plenty of choice and the cakes and pudding are wonderful and all home-made".

We observed mealtimes on both floors. Tables were dressed with tablecloths however no condiments or cutlery were available. Cutlery was handed to people when meals were presented. The nurse advised condiments and cutlery were not routinely placed on to tables due to the risk it posed. We saw a risk assessment was in place.

People were offered a drink whilst they sat at the dining table. Staff enquired if people would like to protect their clothes and offered a bib. Meals were served by the chef from a hot trolley; they engaged with people and were aware of people's dietary requirements. People were reminded of their choice of meal and were offered an alternative if they declined. We saw throughout the meal time staff were attentive and noticed if people were not eating. They were quick to offer the person support. One care worker said, "[Person] would you like a little help, can I cut that up for you." Another said, "[Person] do you not like it, would you like something else?"

We noted people on a soft diet were served their meal after the main meal had been served. 45 minutes lapsed before those on a specific diet received their meal. We observed one person sat at a table with two other people who had received their meals and support. The person was clearly hungry and repeatedly tried to take food from another person's plate. When the other person on the table attempted to give the person a piece of meatloaf staff intervened. We discussed this incident with the manager and the fact people who received a specific diet were made to wait for a long period. The manager advised, "Ancillary staff have received training to enable them to support people at mealtime. They change uniform whilst supporting people to maintain infection control." We asked if this issue had been identified in the mealtime experience audit. They advised it had not but they would look in to the matter further.

Staff told us they had recently been to a presentation for the introduction of a new menu and meal time experience programme. The manager told us, "Pictorial menus will be available and people will be shown plated meals rather than asked." They continued, "No menus are on display today as they are being printed, it starts on Monday. The Nutrition team is coming to the home to train staff; families are also invited to taste the new meals."

We saw evidence in people's care records that the provider ensured people had access to external health professionals when required such as the falls team, optician, dietitian, tissue viability nurse and chiropodist. People's care records documented within the professional visits section contact with GP visits, social workers, optician, dentist, and reported any follow up action required.

Is the service caring?

Our findings

During the last inspection our observations between staff and people using the service did not demonstrate that staff always treated people with respect and dignity.

Improvements were observed throughout this inspection with staff showing many acts of kindness towards people and ensuring their needs were being met. Relatives and people using the service told us staff were kind and caring. One person told, "They are lovely." One relative said, "All the staff are fabulous." Another said, "They can do no wrong."

Relatives told us care staff treated their relative with respect and dignity. One relative said, "Staff are always respectful to [my relative] and me." Another said, "Everyone from the manager to the painter are respectful."

Staff we spoke with recognised the importance of promoting people's dignity. Staff were able to describe how to treat people with dignity and respect. One care worker told us, "I knock on a person's bedroom before going in and keep people covered during personal care." We noted staff knocked on doors and waited for permission before entering. One staff member said, "I treat people as I want to be treated, we work in their home."

We observed interactions between staff and people using the service over two days. We also overheard interactions when staff were not aware of our presence. On one occasion we heard one care worker chatting to a person encouraging them to sing a wartime song. The care worker remarked, "[Person] what's that song you were teaching me the other day, can we sing it again". Together they gave a full rendition and were heard happily laughing at the end.

Staff were responsive to people's requests and worked well as a team to ensure people's needs were met. We observed one person become distressed as they wished to see their relative. Care workers immediately reassured and comforted the person, they sat with the person and reminded them their relative would be visiting soon.

Staff addressed people with their preferred name and had knowledge of their families and the people important to them. When talking to people we witnessed care workers lower to the person's level, obtain eye contact and place an affectionate hand on their shoulder when addressing them. All staff were polite and considerate, and gave people ample time to respond when asking a question and listened to them patiently.

Staff tried to maintain people's independence when supporting them. For example, where people were supported with their meal, staff asked how the person wished to be supported either to cut up food or supported to eat. People were not rushed; care workers were patient with people and allowed people as much time as they needed.

We observed visitors were welcomed throughout our visit. Relatives told us they could visit at any time and

they were always made to feel welcome. One relative told us, "I visit every day and am always made welcome." Another said, "The staff work very hard and put the people first."

Where people had no family or personal representative we saw the home provided information about advocacy services. In the entrance of the home we saw information displayed outlining the support available and detailing the local advocacy service. Information was also available for the support of family carers.

Is the service responsive?

Our findings

During the two day inspection we did not observe any organised activities taking place. The manager told us a new activity co-ordinator had recently been recruited and was due to start the following week. They provided us with an activity planner for the month ahead which included activities such as 1:1 life stories, pampering sessions, garden activities, music and singalong and 'Let's get moving exercise class.' We saw photographs of people engaging in activities on display. We noted the home had plenty of planned group events including a summer fayre and garden events which including planting and creating hanging baskets.

We did not observe any improvements in the activities designed for people living with dementia. During our inspection we did not see any reminiscence activities or encouragement by staff to engage in meaningful activity. Whilst the home had a comprehensive activity plan we noted none were specifically for people living with dementia which is a large number of people living at Willowdene. Following our August 2015 inspection we made a recommendation that the registered provider considers current guidance on caring for people living with dementia including the provision of meaningful activities and takes action to update their practice accordingly. We saw dementia awareness face to face training had been completed by 71% of staff. However this was lower than the provider's aimed target of 90% completed.

The manager told us the home had recently purchased specific dementia games which had yet to arrive. They also told us how one person likes to dust so is given a duster when the cleaner is in their area. The manager told us staff were creating a dementia friendly dining room called the Bistro which was opening the end of April. They said, "Visitors will be able to come and have a cup of tea and a cake with their relative." A relative told us, "[The maintenance person] will come to [Person] and ask them what to do to with a bit of plumbing work. My [relative] use to be handy it's so nice they ask."

Care records contained detailed care plans and covered such areas as safe environment, personal hygiene, oral care, dietary, communication, mobility, falls, activities, spiritual needs and medication. We saw care plans outlined how to support the person. For example, with communication, 'Staff to speak to [Person] and explain before carrying out care to minimise feelings of anxiety or embarrassment.'

All care records we reviewed were up to date and reviewed monthly, evaluations were evident in people's records whose needs had changed. For example, one person's dietary care plan had been rewritten and a risk assessment had been added following a visit to the speech and language team (SALT). We asked to view the monthly care plan audits. The manager advised they had received support from the local authority and they had conducted the care plan audits. The provider did not have their structure in place to review care plans.

Whilst care records held information detailing how staff were to support a person there was limited or no information about the person themselves or their life history, interests and aspirations. We saw two care records contained a short statement which gave a person's recent history. The manager told us, "The co-ordinator is carrying out individual 1:1 life stories with people and families have been invited to take part too."

The provider had a complaints policy and procedure which was on display in the entrance of the building. We noted one complaint recorded and saw it had been investigated with the complainant receiving a full written conclusion of the investigation. We saw the provider had a process for reviewing complaints monthly to determine if trends or patterns required further investigation. Relatives we spoke with had no concerns or complaints about the service their relative was receiving. One relative told us, "There are no issues."

Is the service well-led?

Our findings

In August 2015 inspection we identified that the provider did not have effective quality assurance processes to monitor the quality and safety of the service.

We asked the peripatetic manager what systems were in place to monitor the quality of the service and requested to see evidence of specific audits or quality checks, including staff recruitment records, safeguarding, accidents and incidents, care plans and medicines. They advised monthly audits were carried out in all areas.

Accidents and incidents, complaints, falls trend analysis and pharmacy audits were the only quality assurance located during our inspection. Following the inspection the manager provided copies of monthly audits in respect of meal time experience, medicines and daily walkabouts. We saw since the start of 2016 monthly audits had been carried out. Whilst improvements had been made in regard to the assessing and monitoring of the quality of the service people were receiving, concerns we identified during our inspection were not always detected. For example the confirmation of recruitment checks within staff files and the lack of personal information within care plans.

The manager had been in place for 15 weeks at the time of our inspection. We saw from records and observations they had introduced a number of initiatives. We saw a £15 voucher incentive for staff to achieve 100% completed training. The manager had given ownership of projects to staff, who embraced the opportunity. For example, the ancillary lead had responsibility to organise rotas for deep cleaning rooms. Funds have been allocated to staff to create the 'Bistro' and redesign of three bedrooms.

The manager told us, "I am open to suggestions and change. I take it to the team." We saw staff had recently been in consultation about the shift patterns and the overall vote was that it remained as it was. The manager said, "My nurses are spectacular and the staff work so hard." They told us they were supported by the area manager and the directors of the company.

Willowdene had a clear vision, 'Our residents do not live in our workplace, and we work in their home. Excellent care is the Norm.' Staff demonstrated this ethos throughout their work and were able to describe how they made this happen. We saw the manager had introduced three objectives for the 12 months ahead. One reported, 'To train staff in dementia care so we can be specialist in the field.' They told us, "If I can have the residents smile and the families on board I am happy."

Staff had structured opportunities to share information and give their views about the service people were receiving. The manager had introduced monthly team meetings for kitchen/ancillary, clinical, care staff and a general meeting. We saw these had regularly been held since the beginning of 2016. One care worker said, "[Manager] is really supportive and listens to you." An ancillary person told us, "We have meetings and now get to know what is happening in the home." Another care worker told us, "[Manager] has made a massive difference."

We looked at what the provider did to seek relatives and people's views about the quality of the service. The manager told us they had an open door policy. We saw the manager had introduced a weekly 'Tea with me' time set aside for relatives and people using the service. The manager told us, "It's an opportunity to have a cup of tea and a chat but people can come to me anytime." We saw monthly meetings were also held regularly. They advised that a 'residents' and relatives questionnaire' had recently been sent out.

We noted from one person's daily notes they had returned from hospital with a grade 3 pressure sore. This information is classed as a serious injury and the home has a duty to send a notification to the Care Quality Commission (CQC). The manager advised a notification had been sent however on reviewing all notifications we found that was not the case. We noted the manager had notified the CQC of all other significant events which have occurred in line with their legal responsibilities.

The manager had begun the first stage of their application to become a registered manager.