GCH (South) Ltd

Willowmead Care Home

Inspection report

Wickham Bishops Road
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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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence, and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

About the service
Willowmead Care Home is a residential care home providing the regulated activity of personal care to up to 60 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 49 people using the service within 2 houses [Hatfield House and Wickham House].

People's experience of using this service and what we found

Right Support:
Staff did not do everything they could to avoid restraining people. There was a lack of evidence to demonstrate how the provider learned from those incidents and how they might be avoided or reduced in the future.
People had a choice about their living environment and were able to personalise their rooms.
Staff supported people to take part in activities.
Staff communicated with people in ways that met their needs.
Staff supported people with their medicines in a way that achieved the best possible health outcome. We have made a recommendation about medicines being stored securely and PRN protocols being developed and implemented.

Right Care:
People received care that was kind. Staff understood and responded to people's individual needs.
The service had enough staff to meet people's needs and keep them safe, but improvements were required to ensure the skill mix of staff was appropriate and the use of agency staff reduced. We have made a recommendation about this, staff training and induction.
Risks people might face were mostly assessed and recorded.

Right Culture:
Staff knew and understood people well and were responsive to their needs.
Staff respected people's choices and wherever possible, accommodated their wishes.
Staff felt respected and supported by the manager and deputy manager.
The service apologised to people, and those important to them, when things went wrong.

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 Requires Improvement [Published October 2022]. The service remains rated Requires Improvement following this inspection. This service has now been rated Requires Improvement for the last 2 consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding and risk. A decision was made for us to inspect and examine those risks. We found that improvements were required for safeguarding, risk and to the provider's quality assurance arrangements.

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 COVID-19 and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We have identified breaches in relation risk management, safeguarding and quality assurance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**

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 Health and Social Care Act 2008.

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 practice we can share with other services.

Inspection team
The inspection was completed by 1 inspector and an 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.

Service and service type
Willowmead Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Willowmead Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. Since April 2023, the provider had appointed a new manager to oversee the service.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the Local Authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 5 people who use the service about their experience of the care provided. Where people were unable to talk with us, we observed people's interactions with staff. We spoke with the manager, deputy manager and 4 members of staff. We also spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed 6 people's care files and 5 staff personnel files. We looked at the provider's arrangements for managing safeguarding concerns, risk and medicines management, staff training, induction, and supervision data. We also looked at the service's quality assurance arrangements.

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 our last inspection we rated this key question Requires Improvement. The rating for this key question has remained 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.

Assessing risk, safety monitoring and management
• Some risks associated with peoples care and support needs had not been identified and assessed. Information relating to how these risks should be mitigated were not recorded.
• Where people had a catheter in place, not all risks associated with the catheter had been considered or recorded. A catheter is a medical device used to empty the bladder and collect urine in a drainage bag. The care plan for 1 person referred to their skin integrity having been compromised and receiving interventions from healthcare professionals. The risks associated with this were not recorded to show the steps required to reduce the risk of further deterioration.
• Where a person's care records demonstrated they could become anxious and distressed and their behaviours impacted on others, we were not assured staff had all the information required to manage people's risks in a safe and effective way.
• We identified shortfalls in staff competence to undertake an evacuation in a fire emergency. Fire drill records between May and July 2023 demonstrated staff's competence to undertake an evacuation in a fire emergency was inadequate and unsafe. No remedial action was taken by the provider to ensure staff were competent and to ensure peoples safety. Not all staff employed at the service had up to date training relating to fire awareness. The provider confirmed where this had lapsed, training had been booked.
• Personal Emergency Evacuation Plans [PEEPs] documented the number of staff and equipment required to ensure a safe evacuation was achieved. Consideration should be made to include information relating to people's specific disability, their ability to communicate and understand instructions especially when they could be anxious and distressed. This is a bespoke plan for people who may have difficulties evacuating to a place of safety without support or assistance from others.

Arrangements were not robust to manage and mitigate risk for people using the service and improvements were required to the service's fire evacuation arrangements. This was a breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

• There were risk assessments in place for other elements of people's care and support needs.
• Appropriate fire detection, warning systems and firefighting equipment were in place and checked to ensure they remained effective.

Systems and processes to safeguard people from the risk of abuse
• Robust processes and procedures were not in place to protect people from avoidable harm and abuse, including restrictive practices. Since our last inspection in August 2022, there had been 7 incidents whereby people had received care and support which was not safe and placed them at risk of harm. Although

safeguarding concerns were raised with the Local Authority and Care Quality Commission for each incident, actions taken to robustly investigate the issues raised were not completed for 2 out of 7 incidents. This did not provide assurance that effective arrangements were in place to protect people from abuse.
• Not all relatives considered their family member to be safe living at Willowmead Care Home. Relative's raised concerns about their family member's physical safety and the security of the premises. Comments included, "I could not categorically be confident they are safe; I worry about some of the care from the carers" and, "There have been a few incidents when [family member] has been hit by others."
• Not all staff had up to date safeguarding training, but the provider confirmed this was booked. However, staff were able to tell us about the different types of abuse and describe what actions they would take to protect people from harm and improper treatment.

This was a breach of Regulation 13 [Safeguarding service users from abuse and improper treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Staffing and recruitment
• Most people and relatives considered there to be enough staff at Willowmead Care Home. Comments included, "There are always people around when I go", "When we go there seems to be plenty of staff around" and, "Every time [family member] requires support, there are staff around. When we visit, we see plenty of staff."
• Concerns were expressed relating to the high turnover and agency usage of staff. The staff rosters showed a high percentage of staff working at the service were from 3 external domiciliary care agencies. The provider confirmed between 1 July 2023 and 20 August 2023 inclusive, no more than 32% of staff were permanent and 68% of staff were from the external domiciliary care agencies. The provider told us the high usage of agency staff was because of the service's rural location. However, regular agency staff were being used to ensure continuity of care for people using the service.
• Our observations during both days of inspection demonstrated there were enough staff on duty to meet people's needs.
• Staff recruitment records demonstrated relevant checks were completed before a new member of staff started working at the service. This included an application form, written references, proof of identification and Disclosure and Barring Service [DBS] checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
• The provider had not ensured a profile for all agency staff deployed to Willowmead Care Home had been sought. This did not provide assurance that the same recruitment checks as permanent staff had been carried out by the domiciliary care service.

We recommend the provider consider current guidance to ensure there is a significant reduction in the use of agency staff and the skill mix of staff on each shift is appropriate and reflects this.

Using medicines safely
• Safe practices were in place to ensure the proper and safe use of medicines.
• The Medicine Administration Records [MAR] for 14 out of 49 people were viewed and these showed people received their medicines as prescribed.
• The medicine rounds were evenly spaced out throughout the day to ensure people did not receive their medicines too close together or too late. Observation of staff practice showed staff undertook this task with dignity and respect for the people being supported.
• Staff who administered medicines were trained and had their competency assessed to ensure they remained competent to undertake this task safely and to a good standard.
• Medicine audits were completed and indicated a good level of compliance was achieved with few

corrective actions required.
• Not all medicines were stored securely to prevent others not authorised from accessing them. These medicines were not kept locked in a secure cupboard in the person's room. These were immediately given to the manager for safe keeping. PRN [when required] medicine protocols were not completed for all 'when required' medicines.

We recommend the provider seek national guidance to ensure medicines are always stored securely and PRN protocols are developed and implemented to contain enough information to support staff to administer PRN medicines as the prescriber intended.

Preventing and controlling infection
•We were assured the provider was preventing visitors from catching and spreading infections and promoting safety through the layout and hygiene practices of the premises.
• We were assured the provider was supporting people living at the service to minimise the spread of infection.
• We were assured the provider was using PPE effectively and safely. Staff confirmed there were always sufficient supplies of PPE readily available.
• We were assured the provider was making sure infection outbreaks can be effectively prevented or managed. We were assured the provider was responding effectively to risks and signs of infection.
• We were assured the provider's infection prevention and control policy was up to date.

Visiting in care homes
• Relatives were able to visit their family member without any restrictions imposed and in line with current government guidance. We observed a steady flow of visitors to Willowmead Care Home throughout both days of inspection. Comments included, "I can just go anytime" and, "There are no restrictions." Relatives expressed differing experiences about being informed of COVID-19 outbreaks.

Learning lessons when things go wrong
• The provider was open and honest about the shortfalls found during the inspection and acknowledged there was work to do to improve the shortfalls identified.
• Accident and incidents were logged and monitored to identify potential trends and themes.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection in April 2022, we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills, and experience
• Training information provided to the Care Quality Commission demonstrated most staff had attained appropriate training to meet the needs of people using the service. This included training relating to learning disabilities and autism. However, the training plan submitted to the Care Quality Commission demonstrated there were gaps for some members of staff relating to fire awareness, safeguarding, and moving and handling. The provider confirmed training for these topics were planned and booked.
• Not all staff had documentary evidence of having commenced or completed an induction. Not all agency staff deployed to Willowmead Care Home had evidence of having completed an induction prior to the commencement of their first shift. This is important to understand the purpose and nature of the organisation to which they have been sent and to understand their roles and responsibilities.
• Supervisions for staff were completed to review their practice and professional development. Where issues were raised by staff or related to their conduct and performance, no information was recorded to demonstrate how this was being monitored by the provider or manager to ensure staff felt supported, to improve staff's practice and ensure lessons were learned.

We recommend the provider consider current guidance to ensure staffs' training is up to date, inductions are routinely completed, including agency staff and supervisions for staff are followed up.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Effective arrangements were in place to assess people's needs prior to their admission. People's protected characteristics under the Equalities Act 2010, such as age, disability, religion and ethnicity were identified as part of a person's need assessment.

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported to eat and drink enough to meet their dietary and hydration needs.
• People's comments about the quality of the meals provided were positive. Comments included, "The food is lovely, I have no complaints" and, "I like the meals, they are very nice."
• The dining experience for people was positive. People were offered different options of food and drink. The meals were well presented, considering people's individual food and dining preferences. For example, if they liked a big or small plate of food and specific favourite food items.
• Where people required staff assistance this was provided in a respectful and dignified manner. People were not rushed to eat their meal.
• Where people were at risk of poor nutrition, their weight was monitored at regular intervals and

appropriate healthcare professionals, such as dietician and Speech and Language Therapy Team [SALT] were consulted for advice and support.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Staff worked well with other organisations to ensure they delivered good joined-up care and support.
• People's healthcare needs were mostly met, and they received appropriate support from staff. Records demonstrated people were supported to receive medical interventions, for example, from the GP, hospital, district nurse services and other healthcare services.
• Relatives told us they were kept informed of their member of family's healthcare needs but not always of the outcome of any healthcare appointments. Comments included, "I am told when a GP is called" and, "[Family member] hasn't had any appointments but I asked for a GP to look at them. There was no feedback about that."

Adapting service, design, decoration to meet people's needs
• Willowmead Care Home consists of two houses, Hatfield House, and Wickham House. A new building is currently being built and this is due for completion in November 2023, whereby Hatfield House will be dismantled, and people will be relocated to the new premises.
• The physical environment of Hatfield House was tired and worn. The seating arrangements within the communal lounge areas were not always appropriate as the chairs were primarily placed in rows [Hatfield House] or against the wall [Hatfield and Wickham House]. This did not promote good dementia care.
• There were limited designated quiet areas for people to go to, other than the office, the dining room, or their bedroom. There was no designated area for people to see visitors in private.
• People's diverse needs were respected as their bedrooms were personalised to reflect their own interests and preferences.
• Adaptations and equipment were in place in order to meet peoples assessed needs.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

• People's capacity to make decisions had been assessed and these were individual to the person.
• Where people had bedrails in place to keep them safe and to stop them falling or a sensor mat to alert staff the person was mobilising, an assessment was completed.
• Staff were observed during the inspection to uphold people's rights to make decisions and choices.
• Staff demonstrated a basic understanding and knowledge of the key requirements of the MCA and how this impacted on people using the service.

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 our last inspection we rated this key question Requires Improvement. The rating for this key question has remained 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; Continuous learning and improving care

- The arrangements to assess and monitor the service were not routinely effective. The provider had failed to identify the concerns and areas for improvement found as part of this inspection from their own quality assurance processes. This lack of oversight placed people at risk of not receiving positive outcomes. Not all internal investigations were robust. Discussions had not been held with external domiciliary care agencies following a high number of safeguarding incidents involving these staff.
- Relatives' comments relating to the management of the service were mixed. Not all relatives deemed the service was well managed or considered there to be a strong and effective person managing the service. For example, whilst some relatives were confident to raise concerns, others were not assured things would change as a result of them making a complaint to the service and management team. However, some relatives told us they had experienced an improvement in the service within the last 6 to 7 months.
- Not all relatives knew who was managing Willowmead Care Home. A relative told us, "I have no idea who the manager is" and, "Sometimes the management team is visible, but I don't know who the manager is."
- Relatives' comments relating to recommending the service to others was variable. Where this was negative, comments included, "I could not recommend the service", "Definitely not" and, "I would say they are okay but if you could find somewhere else, then go there." Where comments were more positive, people told us, "I would [recommend the service], I have no problems" and, "I would recommend them [Willowmead Care Home] to others, [family member] is doing very well."

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 provider submitted statutory notifications to us for significant events that had occurred at the service.
- The management team were aware of their legal responsibilities to be open and transparent. However, not all relatives spoken with felt their concerns would always be acted upon and informed about outcomes.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Since April 2023 a new manager had been appointed to oversee the service. The manager demonstrated an understanding of their key role and responsibilities. However, despite the service's rating of 'Requires Improvement' and concerns raised relating to the previous management team, the manager had not received formal supervision.

• Staff were unaware of the providers values and objectives but instinctively worked within these principles. Staff were not aware of the 'Right support, right care and right culture' principles that should underpin their day to day working practices.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Most relatives believed communication between themselves, and the service required significant improvement. Not all relatives were informed if their family member was unwell or if their family member had returned following a stay in hospital. Relatives told us staff did not routinely offer information about the wellbeing of their family member. A relative told us, "Communication is not brilliant. We always ask about [family member] when we are there. We don't get a lot of unsolicited information."

Systems were not robust enough to evidence effective oversight of the service or ensure suitable arrangements were in place to assess and monitor the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider recognised the importance of seeking people's, relatives, and staff's views about their experience of Willowmead Care Home through the completion of a satisfaction survey in June 2023. An analysis of the outcomes was expected in due course.
• 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.

Working in partnership with others
• Information showed the service worked with others, for example, the Local Authority, healthcare professionals and services to support care provision.

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 Arrangements were not robust to manage and mitigate risk for people using the service and improvements were required to the service's fire evacuation arrangements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment All incidents of abuse were not investigated and followed up.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not robust enough to evidence effective oversight of the service or ensure suitable arrangements were in place to assess and monitor the quality of the service.