Young@heart (The Willows) Care Home Ltd

The Willows Care Home

Inspection report

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10 March 2016

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

The Willows Care Home is registered to provide accommodation for up to 27 people who require personal care. At the time of our inspection 14 people were living at the home.

We carried out an unannounced comprehensive inspection of this service on 10 & 11 November 2015. After that inspection we received information about concerns in relation to the service. As a result we undertook a focussed inspection on 10 March 2016 to look at concerns in relation to people's safe care and treatment. This report only covers our findings in relation to this. 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

There was a manager in post. They were not yet registered with us although they had submitted an application to CQC, which was in progress. A registered manager is a person who has registered with the Care Quality Commission to manage the service like registered providers; they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

We found people to be at risk of not receiving safe care and treatment due to staff failing to follow guidelines within one person's risk assessments. This placed them at significant risk of harm. Poor record keeping meant another person was at risk of not having changes to their behaviour identified and responded to ensure their safety.

One person was at risk of not seeing their GP when changes to their wellbeing had failed to be identified and recorded on incident forms so that the manager had a detailed overview of all the incidents and accident where this person had fallen over a period of time. Their daily records confirmed a significant deterioration in their mobility and wellbeing over this period of time.

People who were at risk of inadequate nutrition and hydration did not have an assessment that identified what their daily intake should be so that any concerns could be identified so that immediate action could be taken. One person was also at risk of not receiving care appropriate to their nutritional and hydration and their end of life care.

People's care plans relating to developing pressure sores had risk assessments and guidelines in place.

We found one breach of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

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

The service was not safe.

People were at risk of not receiving safe care and treatment due to failure to follow guidelines on one person's risk assessment.

One person was at risk of not having changes to their behaviour identified through inaccurate records which placed them at increased risk of harm.

Two people were at risk of not receiving care and treatment relating to their nutritional and hydration and end of life care. Due to lack of assessments and inaccurate records.

Incidents forms were not always being completed for one person who over a period of time had fallen. Their care plan did not reflect the change to their support and mobility and there was no recorded medical assistance sought over this period of time even though their mobility had deteriorated significantly.

The Willows Care Home

Detailed findings

Background to this inspection

We undertook an unannounced comprehensive inspection of this service on 10 & 11 November 2015. After that inspection we received information about concerns in relation to the service. As a result we undertook a focussed inspection on 10 March 2016 to look at concerns in relation to people's safe care and treatment.

We inspected the service against one of the five questions we ask about the services: is the service safe.

The inspection was undertaken by two adult social care inspectors and one adult social care inspection manager.

We were unable to speak with people living at the home as they had communication and language difficulties associated with their dementia. We spoke with the provider, the manager, the deputy manager, the house keeper, the laundry assistant, and four care staff. We looked at four people's care records, incident and accident records, policies and procedures and medicines management records. We looked around the premises, observed care practices and the storage of medicines.

Before our inspection we reviewed information relating to people's safe care and treatment. We reviewed the provider's monthly report, notifications and intelligence we had received. Notifications are information about specific important events the service is legally required to send us.

Inadequate

Is the service safe?

Our findings

The service was not safe.

The provider did not ensure people received safe care and treatment. For example, one person had a detailed risk assessment to guide care staff how to support them to minimise the risk of harm. The provider, manager and staff were not following this risk assessment, which placed the person at risk of harm. We highlighted this to the provider and manager at 11.00, but by 17.00 no action had been taken to mitigate against this risk. The provider, manager and staff all gave contradictory explanations about this person's care needs. This meant the agreed approach to keep this person safe was not being followed and placed them at significant risk of harm.

We found areas of the home had personal protective clothing, clinical waste bags and red disposable bags left accessible to people in bathrooms around the home. Items such as these had been identified as a significant risk to one person's safety. The provider and manager felt by removing these items placed other people at risk of poor infection control procedures. This was their explanation for not following the persons' individual risk assessment. This placed all people living at the home at risk of harm due to the provider not following individual risk assessments and completing risk assessments that placed other people at risk of harm.

We found one person was at risk of not having their care needs met due to risks not being accurately recorded. For example, we reviewed the daily records for this person who had become upset on two separate occasions on the same day. They had a behaviour chart in place where staff should record when they became upset. We reviewed the behaviour chart for this day and found staff had recorded the person had been settled all day when in fact their daily records confirmed they had been upset. Staff confirmed they recorded all changes to this person's behaviour on these behaviour charts. This was so any changes to their behaviour could be immediately identified and actions taken. The manager confirmed staff were responsible for completing this person's behaviour chart. The completion of these behaviour charts were part of the person's care plan and risk management plan. They were unable to explain to us why these charts had not been completed accurately. This meant due to inaccurate recording of this persons change in behaviour they were at risk not having their risk management plan followed which placed them at significant risk.

We reviewed another person's care where concerns had been raised that medical assistance had not been sought for them after becoming unwell. Daily records showed they had fallen and hit their head. Medical advice was sought and given to staff following the fall. The daily records confirmed over the next eight days the person's mobility deteriorated and at times they were feeling sick and dizzy. They had required assistance and support from two staff and had also needed to use a wheelchair at times. During these eight days the person had fallen three more times. This person had not been seen by a GP despite them falling and their wellbeing and mobility changing significantly. They only saw a doctor after they were admitted to hospital eight days after the initial fall, following another fall and becoming significantly more unwell.

The person's care plan and risk assessment confirmed they were, 'Mobile and independent with all mobility'. Their risk assessment had not been updated to reflect their change in mobility and support over this eight day period of time. We reviewed the incidents and accidents logged also over this period of time. Only one of the three falls had been recorded. We spoke with the manager regarding the two missing incident forms. They confirmed they were not aware of the other falls this person had sustained. This meant the person did not have an up to date risk assessment and care plan that reflected their significant change in their mobility and wellbeing. No action had also been taken to prevent similar falls from occurring which placed them at significant risk. Staff had not ensured when changes to this person's health were identified this was raised with their GP.

We found people were at risk of not having adequate assessments and inaccurate records relating to their care and treatment specifically to their nutrition and hydration needs and end of life care. This was due to people not having their identified daily requirement assessed and poor records that did not accurately confirm what people should and had received. We reviewed two people who were considered at risk of not eating and drinking enough. Each person had their food and fluid intake monitored. Their care plans had a nutritional assessment as well as a MUST (Malnutrition Universal Screening Tool) but there was no identified requirement of what these people should be receiving each day. This meant they were at risk of inadequate quantities due to no assessment guiding staff to what they should be receiving each day.

Fluid and food charts had been put in place to enable the staff to monitor their intake. These did not accurately record what both people had to drink or eat as they did not record the quantities people were given. For example, one person's records stated 'yoghurt - small and tea - ate all' but did not say of what size pot or the volume of liquid. We raised our concerns with the manager .The manager, stated they did not know how much fluid people should have and that they should probably contact the GP to ask.

One of the two people also had recorded in their care plan they were on 'end of life care'. The manager had stated at the start of the inspection no one in the care home was receiving this type of care. This meant the person could be at risk of not receiving appropriate care due to conflicting knowledge and records relating to this persons care. This meant people were at risk of not having safe care and treatment in relation to their nutrition and hydration and end of life care due to poor assessments and inaccurate records.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed two people who were at risk of developing pressure sores. Their care plans confirmed what support they required to manage these risks. Repositioning charts confirmed care had been provided as described in their care plans. Our observations confirmed people were being repositioned. This meant during our inspection people who were at risk of developing pressure sores were having their position changed to ensure their care needs were being met.

Medicines were being stored safely. They were in a locked medicines cabinet which was secured to the wall and in a locked room. Medicines which required refrigeration were locked to ensure their safety. Fridge temperatures confirmed medicines were being stored at the optimum temperatures. Medicines that required disposal were recorded in a book and locked away whilst they were awaiting collection from the pharmacy. Medication administration records (MAR's) contained photographs of each person but some were not dated. This is important as it ensures when the photograph was taken so reflect a true likeness of the person. The deputy manager said they understood the importance of the photographs having dates and explained those without a date had been taken recently. As the MAR's for these people had been recently updated the deputy manager explained they would be able to add the dates next to the photos as they

knew when the photographs have been taken.

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 12 HSCA RA Regulations 2014 Safe care and treatment This was a breach of regulation 12 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. People were at risk of unsafe care and treatment due to the provider not following risk assessments in place to prevent one person who was at risk of harm. One person did not have an up to date care plan when their mobility had deteriorated and records placed people at risk as there was not an accurate account of people food and fluid intake.

The enforcement action we took:

imposed a condition