Angel Plus Homes Ltd

Willowbank Rest Home

Inspection report

42 Lancaster Lane
Clayton-le-Woods
Leyland
Lancashire
PR25 5SP

Tel: 01772435429

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17 March 2016

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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 caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This comprehensive inspection was unannounced, which meant the provider did not know we were coming. It was conducted on 17 March 2016.

Willowbank Rest Home is registered to provide care and accommodation for up to 19 adults. The home is situated on the outskirts of Leyland in a quiet residential area and is within easy reach of Preston and Chorley. All accommodation is provided on a single room basis and there are a variety of communal areas for residents' use. Bathrooms are located throughout the home. A range of amenities are available in the area and public transport links are nearby. There are ample car parking spaces available adjacent to the premises.

This was the first inspection of this service since the change of ownership in November 2015. We identified some areas where improvements needed to be made These are detailed within each relevant section of the report.

People who lived at Willowbank told us they felt safe being there and we found that the recruitment practices were robust, which helped to protect people from harm. There were sufficient staff on duty on the day of our inspection and it was observed that staff were always present in the communal areas of the home.

The management of medicines could have been better and there were areas of the environment and external grounds, where improvements to safety were needed. The window restrictors were not robust and therefore the windows could have easily been forced open. The hot water temperatures were excessively high in some areas, which created a potential risk of scalding. The hoists had been serviced in accordance with recommended guidelines.

Some areas of the home could have been cleaner and more hygienic. Infection control practices could have been better. For example, the external clinical waste bin was unlocked, which potentially created a risk of cross infection.

We noted that people were supported to mobilise, when help was needed and freedom of movement was evident within the home. We observed that call bells were answered in a timely manner.

Care plans did not always reflect people's assessed needs and some care records provided conflicting information. This did not give the staff team clear guidance about how individual needs were to be best met.

The provision of meals could have been better, although we saw people being supported with their meals in a sensitive manner.

Deprivation of Liberty Safeguard (DoLS) authorisations had not always been extended, in line with the

requirements of the Mental Capacity Act.
Records showed that people's mental capacity had been considered when developing the plans of care, but such assessments were generic and not decision specific. We made a recommendation about this.

We saw people being asked verbally for their consent before care and support was delivered and some consent forms were present in the care files we saw, but these were not always signed and the area of consent could have been extended to incorporate more areas of care and support. We made a recommendation about this.

The staff team were well supported by the management of the home, through the provision of information, induction programmes, supervision and appraisal. The majority of staff we spoke with had a good understanding of people in their care and were able to discuss their needs well.

Interaction by staff with those who lived at the home varied in quality. Some members of staff provided good, sensitive and caring approaches, whilst others failed to promote people's dignity and respect.

The call bell system was noted to produce a loud, high pitched tone, which could have been quite disturbing for those who lived at the home. We made a recommendation about this.

Records we saw failed to demonstrate that those who lived at Willowbank had the opportunity to be assisted with regular bathing. We made a recommendation about this.

Social care profiles were in place in each person's care file, which reflected peoples' preferences and what they liked to do. However, we found that needs assessments had not always been conducted before people moved in to the home and plans of care were not consistently person centred.

Activities were being provided during our inspection and good humoured interaction took place between staff and those who lived at Willowbank.

Complaints were being well managed.

Records showed that people's views about the quality of service provided were sought in the form of surveys and meetings.

The provider had forwarded the required notifications to CQC, as and when required. Comments we received from community professionals were all positive.

The system for assessing and monitoring the quality and safety of the service provided was not always effective. This did not allow for shortfalls to be identified and improvements to be made.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for person centred care, dignity and respect, safe care and treatment, safeguarding service users from abuse and improper treatment, meeting nutritional and hydration needs and good governance.

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

Requires Improvement

People who lived at Willowbank told us they felt safe and we found the recruitment practices were robust. There were sufficient staff on duty on the day of our inspection and it was observed that staff were always present in the communal areas of the home.

The management of medicines could have been better and there were areas of the environment and external grounds, where improvements to safety were needed.

Some areas of the home could have been cleaner and more hygienic. Infection control practices could have been better.

We noted that people were supported to mobilise, when help was needed and freedom of movement was evident within the home. We observed that call bells were answered in a timely manner.

Is the service effective?

Requires Improvement

Care plans did not always reflect people's assessed needs and some care records provided conflicting information. This did not give the staff team clear guidance about how individual needs were to be best met.

The provision of meals could have been better, although we saw people being supported with their meals in a sensitive manner.

Deprivation of Liberty Safeguard (DoLS) authorisations had not always been extended, in line with the requirements of the Mental Capacity Act. Records showed that people's mental capacity had been considered when developing the plans of care, but such assessments were generic and not decision specific. We made a recommendation about this.

We saw people being asked verbally for their consent before care and support was delivered and some consent forms were present in the care files we saw, but these had not always been fully completed and could have been extended,

The staff team were well supported by the management of the

home, through the provision of information, induction programmes, supervision and appraisal. The majority of staff we spoke with had a good understanding of people in their care and were able to discuss their needs well.

Is the service caring?

Requires Improvement

Interaction by staff with those who lived at the home varied in quality. Some members of staff provided good, sensitive and caring approaches, whilst others failed to promote people's dignity and respect.

The call bell system was noted to produce a loud, high pitched tone, which could have been quite disturbing for those who lived at the home. We made a recommendation about this.

Records we saw failed to demonstrate that those who lived at Willowbank had the opportunity to be assisted with regular bathing. We made a recommendation about this.

Is the service responsive?

Requires Improvement

During our inspection we 'pathway' tracked the care of four people who lived at the home. Social care profiles were in place in each person's care file, which reflected peoples' preferences and what they liked to do. However, we found that needs assessments had not always been conducted before people moved in to the home and plans of care were not consistently person centred.

Activities were being provided during our inspection and good humoured interaction took place between staff and those who lived at Willowbank.

Complaints were being well managed.

Is the service well-led?

Requires Improvement

Records showed that people's views about the quality of service provided were sought in the form of surveys and meetings.

The provider had forwarded the required notifications to CQC, as and when required. Comments we received from community professionals were all positive.

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made.

Willowbank Rest 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. We also looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

This unannounced inspection was carried out on 17 March 2016 by three Adult Social Care inspectors from the Care Quality Commission (CQC).

At the time of our inspection of this location there were 15 people who lived at Willowbank. We were able to speak with seven of them. We also spoke with three staff members and the registered manager of the home.

We toured the premises, viewing all private accommodation and communal areas. We observed people dining and we also looked at a wide range of records, including the care files of six people who used the service and the personnel records of three staff members who had been employed since our last inspection.

We 'pathway tracked' the care of four people who lived at the home. This enabled us to determine if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed. Other records we saw included a variety of policies and procedures, medication records and quality monitoring systems.

The provider returned the completed Provider Information Return (PIR), within the requested timeframes. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to this inspection we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us since our last inspection, such as serious incidents, injuries and deaths. We were in regular discussion with local commissioners and community professionals about the service provided at Willowbank. We asked 23 community professionals for their feedback and we received five responses; some of their comments are included within this report.

Requires Improvement

Is the service safe?

Our findings

One person we spoke with, who lived at the home said, "I could not feel safer. All the lasses are really great and eager to help." Another commented, "I don`t go out of my room very much, but if I ring the bell a carer comes pretty quickly."

A family member told us, "I have never witnessed anything that has bothered me. Not at all. I feel everyone here is kept safe. The carers are really attentive."

During the course of our inspection we toured the premises. We found the window restrictors to be insubstantial. These could have easily been forced from the window frames to allow the windows to be opened fully. This created a potential risk for the people who lived at Willowbank. The provider should take appropriate advice and source suitable window restrictors, in order to adequately safeguard those who live at the home.

We noted other areas, which created potential hazards for those who lived at Willowbank. There was a cupboard on the ground floor, which was secured in the closed position by the means of a latch on the outer face of the door. Within this cupboard were some ladders, a walking frame and a hoover, which were easily accessible by anyone passing this area of the home. We observed two people who were living with dementia walking freely around the environment, which was pleasing to see. However, the premises needed to be maintained in a safe manner throughout to reduce the possibility of harm towards those who lived at Willowbank.

There were two wooden benches stored in the outside shed, which also housed food stuffs and cleaning products. The shed was left open during the day, which could have been potentially hazardous for those people who used the external grounds of the home. We were told that this shed was locked when the kitchen staff had finished their shift.

The garden area was not fenced and was not secure. It was easily accessible from the surrounding area, or someone could easily exit the grounds from both sides of the building. We were told by the registered manager that people made use of the garden in good weather, but that it had not yet been made ready for this year.

We looked at how environmental safety checks were being managed. We found documentation which showed regular checks were carried out in areas, such as emergency lighting, call bells, bed rails, wheelchairs and hot water temperatures. However, we tested the temperature of hot water being supplied in several locations throughout the home and found it to be at a far higher temperature than that which had been recorded a few days prior to our inspection. The highest temperature we recorded was 54 degrees Celsius, which was far outside safe recommended maximum temperatures. The water outlet, which was supplying hot water at 54 degrees, was from the wash hand basin in the first floor toilet. This had been recorded at 26 degrees a few days earlier.

We found that the provider had not always ensured that the premises were safe to use for their intended purpose. This was in breach of regulation 12(1)(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted the entrance to the home was malodourous, which did not promote good infection control practices and which did not provide a pleasant welcome for people visiting Willowbank.

Some parts of the premises could have been cleaner, such as bathrooms and toilet facilities. We noted cleaning schedules were available in bathrooms and toilets and we saw that some of these showed two hourly checks had been conducted. However, the underside of a bath seat was very dirty; the underside of a toilet seat was also dirty; an encrusted urine bottle was present on a shelf in one of the bathrooms. We asked a cleaner about this, who told us it was a carers' responsibility to clean the urine bottles. We then alerted a care worker, who removed the urine bottle to clean it. There was another dirty urine bottle on the floor of a second bathroom.

Other areas which needed attention, in order to promote good standards of cleanliness and hygiene were; the pipe work in some of the bathrooms and toilets was not boxed in, which made these areas difficult to clean thoroughly and there was a bar of soap on the end of one bath, which indicated this was used communally for those who used that bathing facility. We saw good hand washing guidelines were displayed and staff members wore protective clothing when carrying out domestic duties and when serving meals. However, there was no hand soap or sanitizer in some areas of the home, such as bathrooms and private accommodation.

The provider had recently commissioned the building of a pen for the outside bins. However, we found the clinical waste bin to be unlocked, which was a concern in relation to safety and infection control protocols. The registered manager was unaware that these bins needed to be secure, as she asked, "Should they (the bins) be locked all the time?"

We found that the provider had not always ensured that risks associated with infection control had been appropriately assessed, in order to prevent, detect and control the spread of infections. This was in breach of regulation 12 (1)(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we assessed the management of medicines. We asked one member of staff, who was responsible for the management of medicines on the day of our inspection if anyone received covert medication (medicines which are concealed in food or drink, to ensure they are taken), but the staff member did not understand what was meant by the word 'covert'. When we explained the staff member told us that no-one received covert medication. However, we found that one person did in actual fact receive covert medication. We did not see any written authority by the person's GP, either within the Medication Administration Records (MARs) or within the plan of care. The care plan had been reviewed monthly and indicated this individual was compliant with medication when their medicines had been administered covertly 'with jam' for several months. We looked at the personnel file of the member of staff we spoke with. We found that she had completed competency assessments in relation to the management of medication, but the assessment itself did not cover the management of covert medicines.

We looked at the MAR chart for one person who was prescribed medication in the morning. The specific directions stated to take 30 – 60 minutes before food. To swallow whole and not to be chewed or crushed. We asked the senior care worker, who was in charge at the time of our inspection how this medicine was administered. She stated that it was given in the morning within a spoonful of porridge, whilst the individual was having breakfast. This was clearly not in line with prescribed directions and therefore the medicine

could have been potentially less effective.

We were told that professional advice about medicines was sought by senior carers. However, we could not find any advice or guidance relating to this method of administration for this individual. The plan of care for this person did not state anything about covert administration and we could find no other documentation to support that a conversation had been had with the GP or any other professional with regard to covert administration of medications. We were told that the reason they were administering this medication in this way was because the resident would 'suck the red outer bit off and then spit them out'.

The MAR chart for another person showed they were prescribed two Paracetamol based medications. The directions for one of these preparations clearly stated, 'Not to be taken with other drugs containing Paracetamol." However, no advice or guidance had been sought from a GP or pharmacist with regard to this.

We found that the provider had not always ensured systems were in place for the proper and safe management of medicines. This was in breach of regulation 12 (1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the medication room to be locked at all times when not in use. The medication trolleys were also locked and secured by a chain to a solid wall. Appropriate written guidance was available and we were told that only senior care staff were allowed to administer medication. Records we saw showed that these staff had received training in the management of medications. Room temperatures had been, in general recorded daily and these were within recommended limits. We saw a record was kept of any destroyed or returned medication with the required signatures. Hand washing facilities and 'do not disturb' aprons were observed in the medication room.

Medicines were checked in at the time of delivery by two members of care staff. MAR charts were seen and no omissions were observed. We observed the lunch time medication round, which was carried out by a senior care staff member. At all times people were asked if they were ready for their medication and were observed while they took it. Drinks were offered with medications, which allowed people to take them more easily. People were asked if they required any pain relief.

Controlled drugs (CDs) were stored appropriately and we saw records that showed they were checked by two staff members when administered. We looked at the records for one person, who required CDs and we found that the remaining balance of medication stock coincided with that in the CD record book.

Medicines were seen to be administered in a safe way. However, occasionally the staff member used bare fingers to administer medications, when the use of a spoon or a plastic cup would have been more appropriate and more hygienic.

Staff members we spoke with told us they had undergone training in relation to safeguarding adults and records we saw confirmed this information to be accurate. They were also fully aware of the whistleblowing policies and were confident in reporting any concerns in the most appropriate way.

We noted a calm atmosphere to be evident throughout our inspection. People who lived at Willowbank were able to move around the home freely and were supported by staff members, when help was needed.

Fire prevention policies were in place and these were prominently displayed within the home. A fire risk assessment had been developed and individual Personal Emergency Evacuation Plans (PEEPS) had been

implemented for each person who used the service. These were retained in a separate folder in the main central office, so that if evacuation was needed the emergency services had sufficient information to assist people to vacate the premises in the most appropriate way.

The most recent inspection by the Environmental Health Officer from the local authority showed a five star rating for food hygiene. This outcome is equivalent to 'very good', which is the highest level achievable.

We noted that staff members were always present within communal areas of the home and that call bells were answered in a timely manner. There were sufficient staff on duty to meet the needs of those who lived at the home.

We found the environment to have easy access for wheelchair users and the less mobile. A wide range of risk assessments related to personal care, mobility, and nutritional requirements were linked to the care plans we looked at. Accident records were completed appropriately and were retained in accordance with data protection, so that personal information was kept in a confidential manner. Records showed that systems and equipment within the home had been serviced in accordance with the manufacturers' recommendations. This helped to ensure they were safe for use.

During the course of our inspection we looked at the personnel records of four people who had worked at Willowbank for varying periods of time. We found that recruitment practices adopted by the home were robust, which helped to keep those who lived at Willowbank safe. Each staff members' file contained two or three written references and Disclosure and Barring Service (DBS) checks. DBS checks highlight if the prospective employee has received any criminal convictions or cautions. This helps the provider to decide if the individual is deemed fit to work with the vulnerable people, who live at the home. Each applicant completed health questionnaires and application forms. Successful candidates from stage one of the selection process then underwent a documented interview, so that any areas for discussion could be further explored.

Requires Improvement

Is the service effective?

Our findings

One person we spoke with said, "To be honest the food could be better. You seem to get enough, but some of it is not nice." Another commented, "The staff are very good and very understanding. If I needed to see a doctor they would arrange it for me." And a third told us, "I am not sure if any agency staff work here, but whoever they are they seem to know what they are doing."

A family member we spoke with said, "I have no concerns at all. If there was anything wrong I know they (the staff) would ring me right away."

We noted that the current care records were kept securely in the manager's office. However, we found an unlocked cupboard in another part of the premises, which contained archived confidential records, which were easily accessible by anyone in that particular area of the home.

We were told that one person who lived at Willowbank could verbally challenge the service at times. We 'pathway' tracked the care of this individual. However, we did not see a specific plan of care in relation to this area of need and therefore the staff team were not provided with appropriate guidance about how care and support was to be delivered.

One of the care files we looked at contained some concerning conflicting information. A Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) authorisation, which had been completed by the GP was at the front of the individual's care records. However, the 'grab' sheet, which contained important details about the person and was also at the front of the care file stated, 'I am for Resuscitation'. This conflicting information could have potentially resulted in inappropriate lifesaving care being provided.
We found that the provider had not always maintained securely an accurate, completed and contemporaneous record in respect of each service user, including a record of decisions taken in relation to care and treatment. This was in breach of regulation 17 (1)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had applied for Deprivation of Liberty Safeguards (DoLS) based on people lacking capacity, not being free to leave the home alone and being continually under supervision. However, a further application had not been made in order to extend one urgent DoLS authorisation and therefore this had expired.

We found that the provider had not always ensured that lawful authority had been granted in order to deprive someone of their liberty. This was in breach of regulation 13 (1)(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two of the inspectors assessed the management of meals and sampled the food served at lunch time. We noted that a choice of hot main courses and deserts were offered. However, the chips and vegetables were both cold, but the pie was very hot. One person did not have any teeth or dentures and it was quite evident that they found it very difficult to eat the pie crust, which was very hard. One person asked for some more

rice pudding, but was told, "There is none left." However, staff told us that alternatives had been offered, but had been declined. We observed that one person told each member of staff he was not hungry, but we did not see or hear any alternative food choices being offered, although two staff members said it was.

The food could not be described as being nutritious home-made cooking and quite a lot of food wastage was observed. This did not support people to receive an adequate well-balanced and nutritious diet.

Dietary requirements were not consistent throughout all the care records we saw. One care plan stated the person required a fortified diet. However, the Chef told us they did not require a fortified diet. Therefore, this person may not have been receiving the correct diet to meet their medical needs, or their care records were inaccurate.

We found that the provider had not always ensured that people's nutritional needs were being fully met. This was in breach of regulation 14 (1)(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked if anyone required assistance to eat and we were told only two people needed help and they were cared for in bed, but that others did need some prompting. At different times, various members of staff came in to the dining area. Staff members acknowledged people by their first names and enquired politely how the person was. We saw one staff member supporting one person to cut their food up and eat their meal, but not before asking first. Hot and cold drinks were available throughout the day and staff offered them to each individual person in turn.

One person the inspectors dined with told us she had enjoyed her meal. We also noted another person was allowed to take her time whilst eating and needed some gentle encouragement from staff, which she received sensitively.

One plan of care we saw was detailed and informative in relation to the person's mental capacity to make some decisions, such as how and where the person wishes to spend the day, what they would like to eat and drink and decisions relating to personal care needs. An extract from the plan of care stated, 'To ensure that (name removed) is continuing to make decisions, which she is able to. Only make best interest decisions for her when necessary. If felt no longer has the capacity to make some decisions then mental capacity tests must be undertaken and nest interest decisions made ensuring least restrictive options available.'

We established that new employees were issued with a range of information when they first started to work at the home, such as the employee handbook, Job descriptions and terms and conditions of employment. These informed them of what was expected of them whilst working at the home and outlined their duties specific to their individual roles.

Records showed that a detailed induction programme was provided for all new staff, which was in line with the nationally recognised care certificate. Modules covered during this initial training included, values, confidentiality, person centred approach, risk assessing, moving and handling, health and safety, fire awareness, first aid, infection control, safeguarding adults and medication management. This helped new employees to gain some knowledge around important areas of care and to prepare them for their specific roles at Willowbank.

Most staff members we spoke with had a good understanding and knowledge of people's individual needs. Two care workers were able to explain in detail the needs of several people who lived at the home. Individual training records and certificates of training were present in staff members' personnel records.

These covered areas, such as moving and handling, dementia awareness, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Records showed that staff members received regular supervision and annual appraisals from their line managers, which were linked to specific knowledge checks. This helped them to improve their work performance and focus on their personal development.

We 'pathway' tracked the care of two people who presented with nutritional difficulties. They were both under the care of the Speech and Language Therapist and records showed that they were both steadily gaining weight, which was pleasing to note. Evidence was available to demonstrate that a wide range of community professionals were involved in the care and treatment of those who lived at the home. This helped to ensure their health care needs were being appropriately met.
During our tour of the premises we noted areas to be dementia friendly. For example, there was a good level of lighting in the toilet facilities and the toilet seats were of contrasting colours, which was considered to be good practice. However, visual prompts, such as picture menus could have been introduced, so that those who lived with dementia were provided with the same opportunities as everyone else to make food choices at meal times.

We saw that mental capacity assessments had been completed. However, these were of a generic nature and covered a range of different areas. A person may have the capacity to make decisions about one area of care, but not another. It is recommended that mental capacity assessments be decision specific in relation to one area of care and support.

We saw consent forms to be in place, allowing staff to administer medicines. However, these had not always been signed and we did not see any consent forms in relation to the sharing of information, provision of care and support or taking of photographs. However, we did hear staff members consistently asking people for their consent before providing care and support, such as cutting up their food or assisting with mobilisation and one plan of care we saw read, 'All staff to gain consent from (name removed).' It is recommended that the consent process is formulised, so that written consent is obtained from the individual receiving the care or support, or their representative, who must be able to provide evidence that they hold Lasting Power of Attorney (LPA) on behalf of the individual or have been awarded Court of Protection (CoP).

Requires Improvement

Is the service caring?

Our findings

Comments from those who lived at the home included, "Carers come in a lot during the day, because I stay in my room. They always have a chat when they come in"; "I recently had my care plan reviewed, just last week and yes, I feel I was involved all the time" and "The carers always knock before they come in. They are very respectful and very patient too."

One family member told us, "Yes. I was invited to his care plan review and felt really involved throughout. They (the staff) were interested in what I thought."

Our observations in relation to staff interacting with those who lived at the home were varied. We saw some good, sensitive and caring interactions between most care workers, the registered manager and several people who required assistance during the day. However, we made several observations, which did not promote people's dignity and were not respectful towards those who lived at Willowbank. For example, we saw one care worker standing over people at lunch time in an overpowering manner and we heard her say quite forcefully to one person, "Why aren't you eating your pie?" We also heard her say sharply to a new resident, who was being assisted to mobilise, "You are supposed to walk with your stick on the floor, not in the air!"

We also observed another member of the care staff team assisting one person to walk down the corridor, but she was 'mimicking' the noises he was making, as she was doing so. These actions were totally inappropriate and undignified for the vulnerable elderly people who lived at the home. Our observations were made within open communal spaces, when our presence was quite evident. Therefore, these members of staff must have considered their actions to be normal every day practice.

We found that the provider had not always ensured that people were treated with dignity and respect. This was in breach of regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care records we examined incorporated the need for privacy, dignity and independence, particularly during the provision of personal care and during our tour of the premises it was clear that some people had their own bedroom door keys. This helped to protect people's personal belongings and to promote independence and privacy. However, we noted blinds to be missing and broken from the large plain glass bathroom window, which overlooked a busy main road. This impacted on people's privacy and dignity. The provider addressed this issue at the time of our inspection. We saw that staff supervision sessions covered dignity in care, which helped the staff team to promote privacy and dignity for those who lived at Willowbank.

We noted that on moving in to the home people were presented with a welcome pack, which was a nicely presented gift of toiletries. This provided people with a warm welcome to the home.

We noted that the call bell system was extremely loud and high-pitched and could easily be disturbing for

those who lived at the home. It is recommended that the provider sources a less piercing, but audible network.

We saw those who lived at the home to be well presented. However, we looked at the bathing records, which were available at the home and found large gaps where bathing had not been recorded. According to these records one person had not had a bath or shower for a period of 13 days and another for 16 days. We discussed this with the registered manager at the time of our inspection, who said that everyone has a bath at least once a week and the provider told us that everyone is offered a bath each day. The registered manager told us that where gaps were evident on the bathing records, it was because these people were none compliant with bathing. However, there was no record of this within their plans of care and no checks had been done to determine periods of none compliance. It is recommended that where people are none compliant with personal care, then this is included within the care planning documentation and entries made on any associated records, as to why omissions are evident.

Requires Improvement

Is the service responsive?

Our findings

One person we spoke with said, "I know the manager and I know she would listen if I had a complaint." Another commented, "Without the manager this place would not run. She would do anything for you. She`s brilliant." And a third told us, "I have done a survey in the past but not for a while, but yes we do get asked what we think."

A relative of one person told us, "We did have a couple of little problems when he first moved in. Nothing serious, but they sorted it straight away."

During the course of our inspection we 'pathway' tracked the care of four people who lived at Willowbank Rest Home. We found that pre-admission assessments were not always present in people's care files. Therefore, evidence was not available to show that people's needs had always been thoroughly assessed before a placement at the home was arranged and therefore the staff team could not be sure that they could deliver the care and support required by each individual who was planning to move in to Willowbank.

The care files were not always person-centred, as they contained some vague statements and conflicting information, which could result in inappropriate care and support being delivered. One of the plans of care plans we saw stated, 'Staff must ensure that any prescribed creams or lotions are applied as per MAR (Medication Administration Record) sheet and associated body map.' However, there were no prescribed local preparations for this individual recorded on their MAR chart.

The plan of care for one person did not reflect the current situation, in relation to the administration of their medicines, as it showed this person was compliant with medications. However, we established that staff were administering medicines for this individual covertly. We were told that this person's medication had been 'crushed in jam' for several months, but care plan reviews did not reflect this information. We did not see any authorisation by the GP to indicate how and when to administer the covert medication.

We found the registered person had not always ensured an assessment of needs and preferences for care and treatment had been conducted and plans of care had not been designed to reflect individual requirements. This was in breach of regulation 9(1)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw social care profiles were in place in each person's care file, which reflected peoples' preferences and what they liked to do. There were also 'grab' sheets at the front of each person's care file. These contained important basic information about each individual, which was very useful to emergency services, such as paramedics, should anyone need an urgent transfer to hospital.

During the morning and afternoon periods we spent some time in the communal lounge with those who lived at Willowbank. Nine people were present and two staff members. We observed activities taking place on both occasions. A full time activities co-ordinator had recently been employed and people told us they enjoyed the activities, which were provided. Good humoured interaction took place and everyone was

invited to take part, which they did.

We visited one person who was sitting in his room alone, with the door closed and no stimulation. A member of staff told us this person was a very quiet and private individual and preferred to remain in his own bedroom. The name of this person's key worker was displayed on their bedroom door. However, we spoke with the named carer, but she was unaware that she was this individual's key worker. She told us that she was not involved in care planning, but did contribute to the completion of daily records. This care worker told us she was in charge on the day of our inspection and went on to explain what duties this involved, such as medication administration, walk-rounds, checks on commodes, beds and sinks in people's rooms, but there was no mention of organising staff or providing guidance and support for the staff team.

We went to look at the exterior of the property and the grounds of the home. The garden area to the rear of the premises had raised planting beds for people to use, which was pleasing to see.

We noted that a system was in place for the recording of complaints received by the home. This included all correspondence with the complainant and a letter of response following the internal investigation. We found that complaints were well managed.

Requires Improvement

Is the service well-led?

Our findings

Those who lived at Willowbank spoke positively about the manager of the home. Comments we received included, "She's (the manager) easy to talk to"; "The manager comes into see me a lot, most days and she asks how I am and if I need anything"; "I talk to the carers and the manager almost every day, so if I had any problems I could talk to any one of them" and "The manager speaks to us all every day. We see her around all the time."

A family member told us, "I think the manager is very nice. She is really approachable and easy to talk to."

The home had recently achieved an external quality award, which showed that a professional organisation had assessed the quality of service provided. We were shown a wide range of internal audits, which were conducted regularly. For example, the directors of the organisation and the manager of the home had introduced full premises audits, including the external grounds. Action plans were drawn up following these audits.

A health and safety audit had been conducted by an external company and 'mock inspections' were conducted, in accordance with the five key areas assessed by the Care Quality Commission, which covered several days and which involved speaking with those who lived at the home. Care plan audits and medication audits had also recently been conducted. However, from the audits we saw on the day of our inspection it was clear that the assessment and monitoring systems in operation at the home were not consistently effective, as they did not identify areas in need of improvement, which we noted during our inspection.

We found the registered person had not established and operated effective systems to assess, monitor and improve the quality and safety of the services provided or to mitigate risks relating to the health, safety and welfare of those who lived at the home and others who used the premises. This was in breach of regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that there was a good retention of staff, with a number having worked at Willowbank for several years. This helped to provide continuity of care. Staff we spoke with generally had a good understanding of their roles and responsibilities towards those who lived at Willowbank. When we asked about DOLs (Deprivation of Liberty Safeguards) requirements and statutory notifications, we were told, "The manager is 'up to speed' with those." However, staff members were also aware of the basic principles and their responsibilities around the Mental Capacity Act.

Records showed that residents meetings were held every month. This allowed people the opportunity to discuss various topics in an open forum, should they wish to do so. The minutes were produced in large font, for easy access and showed that people who lived at Willowbank had been involved in discussions relating to re-decoration, meals and future activities and that changes had been made in accordance with suggestions made by those who lived at the home.

Regular meetings were also held for the staff team, so that any important information could be disseminated throughout the workforce. This enabled those who worked at the home to discuss any relevant topics and to keep up to date with any specific changes.

We saw that surveys for those who lived at the home, their relatives and for community professionals were conducted during the year prior to our inspection. The registered manager told us that these had recently been repeated, although responses had not yet been received. This helped the management team to seek people's views about the quality of service provided.

The provider had forwarded the required notifications to CQC, as and when required. Copies of these were also retained on site for easy reference. Accidents and incidents were documented appropriately and these records were retained in line with data protection guidelines.

The new provider attended the home during our inspection. We discussed the future plans for Willowbank and we were told of the company's intentions to make improvements to the environment and the written policies and procedures of the home. We observed the provider walking around the premises, speaking with people in their private accommodation and the communal areas of the home. This was done in a respectful manner, which was pleasing to see.

We received written responses from five community professionals. Their comments included, 'I have been involved for many years with Willowbank Care Home in supply of medication, medication audits and inspections and staff training around medication issues. I have found no problems in the home, finding the staff and management pro-active in the above areas and receptive to advice and input from the Pharmacy' and 'The Home is very well run and managed; the staff are friendly, welcoming and engaged with the residents. The residents are well cared for and there is a pleasant restful atmosphere. Standards of care are good, and focused on the wellbeing of the residents.'

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care We found the registered person had not always ensured an assessment of needs and preferences for care and treatment had been conducted and plans of care had not been designed to reflect individual requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect We found that the provider had not always ensured that people were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found that the provider had not always ensured that the premises were safe to use for their intended purpose. We found that the provider had not always ensured that risks associated with infection control had been appropriately assessed, in order to prevent, detect and control the spread of infections. We found that the provider had not always ensured systems were in place for the proper and safe management of medicines.

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 We found that the provider had not always ensured that lawful authority had been granted in order to deprive someone of their liberty.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs We found that the provider had not always ensured that people's nutritional needs were being fully met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We found that the provider had not always maintained securely an accurate record in respect of each service user, including a record of decisions taken in relation to care and treatment. We found the registered person had not established and operated effective systems to assess, monitor and improve the quality and safety of the services provided or to mitigate risks relating to the health, safety and welfare of those who lived at the home and others who used the premises.