Bank House Care Homes Limited

Willowcroft Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Good**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of Willowcroft Care Home on 1 September 2016 and the service was rated as good. After that inspection we received concerns in relation to the safety and quality of the service provided at Willowcroft Care Home. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those areas. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Willowcroft Care Home on our website at www.cqc.org.uk.

We inspected Willowcroft Care Home on 6 and 7 March 2017. The inspection was unannounced. The home is a situated in Sutton in Ashfield in Nottinghamshire and is operated by Bank House Care Homes Limited. The service is registered to provide accommodation for up to 40 people. At the time of our inspection 36 people lived at the home.

There was a registered manager in place at the time of our inspection. 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 2008 and associated Regulations about how the service is run.

Risks associated with people's care and support were effectively assessed and managed. However we found that action had not always been taken to protect people from risks associated with the environment, as water temperatures were above the recommended safe level. Swift action was taken to minimise this risk during our inspection.

Although people were supported by staff who knew how to recognise abuse and how to respond to concerns, action was not always taken to reduce the risk of people being placed at risk of harm.

Medicines were managed safely and people received their medicines as prescribed. There were sufficient numbers of staff available to meet people's needs and safe recruitment practices were followed.

People using the service and staff were involved in giving their views on how the service was run. Quality monitoring systems had not proved to be fully effective in identifying and responding to issues, action was underway to address this.

The management team were open and responsive to feedback and took swift action on the concerns identified during this inspection.

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

The service was not always safe.

Risks associated with people's care and support were effectively assessed and managed. However people were not always protected from risks associated with the environment.

Although people were supported by staff who knew how to recognise abuse and how to respond to concerns, action was not always taken to reduce the risk of people being placed at risk of harm.

Medicines were managed safely and people received their medicines as prescribed.

There were sufficient numbers of staff available to meet people's needs and safe recruitment practices were followed.

Is the service well-led?

Good

The service was well led.

People using the service and staff were involved in giving their views on how the service was run.

Quality monitoring systems had not proved to be fully effective in identifying and responding to issues. Action was underway to address this.

The management team were open and responsive to feedback and took swift action on the concerns identified during this inspection.

Willowcroft Care Home

Detailed findings

Background to this inspection

We carried out this focused inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was undertaken to explore information of concern received about the safety and quality of the service and to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We conducted an unannounced inspection of Willowcroft Care Home on 6 and 7 March 2017. The inspection team consisted of one inspector and a specialist advisor who was expert in nursing and mental health. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well led

Prior to our inspection we reviewed information we held about the service. This included information received from the service, including statutory notifications, and from other sources. A notification is information about important events which the provider is required to send us by law.

During our visit to Willowcroft Care Home we spoke with two people who used the service. We also spoke with four members of care staff, two nurses, the registered manager, the quality assurance manager and a representative of the provider.

To help us assess how people's care needs were being met we reviewed five people's care records and risk assessments. We also looked the medicines records of six people, three staff recruitment and training records, as well as a range of records relating to the running of the service including audits carried out by the management team.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

Action was not always taken to ensure people were protected from improper treatment. We found that incidents had not always been referred to the local authority safeguarding adults team when they should have been. We reviewed care records related to one person and found a number of incidents had been documented where they had threatened or physically struck another person who used the service. Over a three month period, records showed there had been three physical altercations between these people and other instances of threatening behaviour. For example one record described an incident where the person was found in another person's room with their fist raised, the record documented that the person was screaming. We spoke with the registered manager about this who told us that they had not made a referral to the safeguarding adults team as they felt this was just an aspect of these people's relationship. The lack of appropriate referral did not assure us that the service was doing all it could to protect people from harm. In response to our feedback the registered manager made a referral to the safeguarding adults team and assured us that action would be taken in future to ensure that incidents of this nature were also referred.

Apart from the above we found that systems and processes to minimise the risk of abuse were in place and being adhered to. Staff we spoke with had an understanding of how to recognise allegations or incidents of abuse and understood their role in reporting any concerns to the management team and escalating concerns to external agencies if needed. Records showed other concerns had been shared with the local authority safeguarding adults team when needed.

Plans were in place which detailed risks relating to people's care and support and how these risks should be managed. When people had been assessed as being at risk of falling preventative measures were in place. Staff carried out frequent checks on people throughout the day and night to ensure their safety and these were recorded. The deputy manager also informed us that they were in the process of implementing a new falls analysis system to improve their practice in this area.

Some people using the service communicated with their behaviour. For these people there were plans in place which detailed triggers to these behaviours and provided guidance for staff on how to respond to keep the person and others safe. However we found that information in plans was not always up to date. We reviewed care records for one person which showed they frequently threw and smashed objects in communal areas. There was no information about this in the person's care plan. Although staff we spoke with had a good knowledge of how to support the person, there was a risk that not all staff would have the necessary information to keep the person and others safe. We discussed this with the registered manager and they took immediate action to update the person's care plan to ensure that all staff had access to the necessary information.

Risks in relation to people developing a pressure ulcer were assessed and planned for safely. Pressure ulcer risk assessments were completed regularly and people who had been assessed as being at risk of developing pressure ulcers were provided with suitable equipment to reduce the risk. We saw that this equipment was being used as specified in people's care plans. Records were in place which provided evidence care had been provided in accordance with the care plans. For example, re-positioning charts were

in place for people at high risk of developing pressure ulcers and these had been completed.

People could be assured that equipment was used safely by staff who had received training. We observed staff supporting one person to transfer using equipment and saw that staff were skilled and confident and provided the person with reassurance throughout.

People were not always protected from risks associated with the environment. People were at risk of scalding themselves due to hot water temperatures in some bathrooms being above the recommended safe level. Although hot water temperatures were being regularly tested, action had not been taken when it was identified that water was too hot. For example records showed that a shower in one of the bedrooms that was in use was significantly above the recommended level of 43°C for two consecutive weeks. This was still the case during our inspection. We shared our concerns with the registered manager and the maintenance person took swift action to ensure that all water temperatures were brought back within a safe range.

During our inspection we observed there were enough staff present to meet people's needs and people were assisted in a timely manner. The registered manager told us they had flexibility in their staffing levels and could increase this based upon the number of people using the service and the complexity of their support needs. The staff we spoke with told us that staffing levels were normally sufficient and that when staffing levels had dropped below the number determined by the provider, the nurse on duty would "help out". Another member of staff told us that the team normally pulled together to cover sickness and other unplanned leave.

People could be assured that safe recruitment practices were followed. The service had taken the necessary steps to ensure people were protected from staff that may not be fit and safe to support them. Before staff were employed criminal records checks were undertaken through the Disclosure and Barring Service (DBS). These checks are used to assist employers to make safer recruitment decisions. Proof of ID and appropriate references had also been obtained prior to employment and were retained in staff files.

People received their medicines on time and as prescribed. Medicines were well organised, stored safely and medicine records were completed accurately. There were protocols in place to guide staff when people were prescribed medicines on an 'as and when required' basis. The team at Willowcroft Care Home were effective in managing people's anxieties and resultant behaviours without the overuse of medicines. We spoke with the relative of one person about the use of medicines and they commented, "It (medicine) is treated as a last resort, they only give it if they have tried everything else."

Staff had been trained in the safe handling and administration of medicines and had their competency assessed annually to make sure they were keeping up to date with good practice. We observed a nurse administering medicines and saw that they followed safe practice. Medicines audits were carried out regularly to ensure medicines were being managed safely.

Good

Is the service well-led?

Our findings

People told us they were happy living at Willowcroft Care Home. One person told us, "Yeah the staff are good." We spoke with the relative of one person who was positive about the support their relation received. We observed that people appeared to feel comfortable and confident to speak with the staff and positive relationships had developed between them.

People who used the service and their families were supported to have a say in how the service was run. We spoke with one person's relative who told us the management team were, "completely accessible" and commented that they had been responsive to past concerns. The management team ran a monthly 'surgery' where the relatives of people who used the service were invited to discuss any issues and provide feedback. Informal meetings were also held for people who used the service to share their views. Many of the people who lived at Willowcroft Care Home were unable to provide meaningful feedback on the service via traditional methods such as meetings. The registered manager explained how they used formal methods of observation to learn from people's behaviours and used this to make changes to the service.

In addition to the above people and their relatives were invited to share their feedback in regular quality assurance surveys. Results of a recent survey showed that people had expressed some dissatisfaction with activities and records showed that this had been addressed with the activities coordinators.

Staff were given an opportunity to contribute to the running of the service in regular meetings. Records of these meetings showed these were used to consult with staff about changes in the service and also to discuss issues and concerns. Action plans were developed as a result of these meetings. Staff we spoke with told us they felt well supported and understood their roles and responsibilities. They were aware of their duty to whistleblow on poor practice and felt confident in raising any concerns with the registered manager. One member of staff described a time when they had raised a concern with the management team and commented, "It was dealt with quickly and well."

There was a registered manager in place who was passionate about her role and took pride in the service. There was a clear management structure within the service including a deputy manager, senior nurses and senior carers who supervised the day to day running of the service. Throughout our time at Willowcroft Care Home the management team were open and receptive to feedback and took swift action to rectify areas of concern we identified during our inspection.

We checked our records which showed that the management team had notified us of events in the service. A notification is information about important events which the provider is required to send us by law.

The registered manager linked with other local services and took part in local management forums to keep up to date with best practice. They explained that the service had recently been nominated to join a national research project with Nottingham University called the National Prevalence Measurement of Quality of Care (the LPZ). This is an annual, independent measurement of care quality in the healthcare sector and focuses on pressure care, continence, nutrition, falls, restraints and pain. The registered manager

explained they hoped this would enable them to gain an understanding of what they were doing well and areas for improvement.

There were systems and processes in place to monitor and improve the quality of the service. The management team conducted a wide range of audits across the service such as auditing the environment, medicines, care plans, health and safety and infection control. The provider employed a quality manager who checked all audits and further checks were carried out by the provider. Observation of staff practice and out of hours spot checks were also conducted regularly to ensure that staff were providing high quality care.

On the whole we found where any issues were identified, actions were recorded as being taken. However we noted that whilst unsafe water temperatures had been noted on maintenance records, action had not been taken in response to this. We shared this with the registered manager and head of maintenance during our inspection, who took immediate action to rectify this issue. The registered manager also informed us that action would be taken to address the training needs of the responsible staff member.

Overall we found that people's care records were accurate and up to date. However we identified that in some cases care plans had not been amended to reflect changes in people's needs or staff learning about how best to support people. For example we spoke with a member of staff who described how they supported a person to reduce their anxiety and distress, however this information was not reflected in the person's care plan. We discussed this with the registered manager who took swift action to update the care plans in question. They also informed us that they were working with the nursing team to ensure that care staff were involved in the reviewing of care plans to make sure that the most accurate information was recoded about people's care needs.