Brookhouse Assets Limited

Willow Lodge

Inspection report

15-16
Moss View
Ormskirk
L39 4QA

Tel: 01695579319

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Willow Lodge is a care home providing accommodation and personal care for up to 22 people aged 65 and over. There were 17 people living at the service at the time of the inspection. Some of the people lived with dementia and required support with their physical needs.

People's experience of using this service and what we found
People told us they felt safe and staff were kind and caring. However, our observations showed that people did not always receive safe care and treatment. Staff had not reported safeguarding concerns to safeguarding authorities including unexplained injuries. People's care was not delivered in a safe environment which had been maintained to acceptable standards. People's bedrooms, communal toilets and ensuites did not have call bells for summon help in the event of an emergency. People's bedrooms did not have additional bedside lighting and lifting equipment had not been inspected and maintained as per manufacturer's recommendation.

People were exposed to risk of the spread of infections due to poor infection prevention practices and poor hygiene standards around the service. People's safety had been compromised due to the lack of robust positive behaviour risk management processes. Risks to people were not adequately assessed and reviewed to identify ways to reduce deterioration. People were not always supported with their medicines in a safe manner.

We have made a recommendation about the need to improve the environment to promote independence and good outcomes for people who live with dementia.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People told us staff sought their preferences, however, staff had made some blanket decisions on people's ability to make specific decisions without assessing their capacity to make their own decisions. The registered provider had not followed national guidance and best practice to support the effective delivery of care. People were not always supported by staff who had the right competences, induction and supervision to meet their needs. Staff supported people to have access to health professionals and specialist support.

The governance and quality checks did not promote the delivery of safe care and treatment. Environmental and governance concerns from our last inspection in 2019 had not been addressed. The provider had not established good governance in line with best practice to improve the care delivered and to ensure compliance with regulations. The provider had not established robust oversight to support staff on the running of the service and compliance with regulations and to monitor people's experiences.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 15 May 2019) and there were multiple breaches of regulation. We issued a warning notice for the safety of the environment and asked the provider to be compliant by November 2020. The provider also completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found little in the way of improvements to the environment and the provider remained in breach of regulations associated with people's safety, medicines, good governance and maintenance of the premises.

Why we inspected
We received concerns in relation to the management of behaviours that can challenge others and safeguarding concerns. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. This inspection was also carried out to follow up on action we told the provider to take at the last inspection.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Requires improvement to inadequate. This is based on the findings at this inspection.

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 coronavirus and other infection outbreaks effectively.

Enforcement:
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

At this inspection we identified breaches in relation to keeping people safe from preventable harm such as unexplained injuries, poor infection control practices, responding to changes in people's needs, the safe maintenance of equipment and premises, seeking consent and poor governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Willow Lodge

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 Care Act 2014.

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
Two inspectors carried out the site visits during this inspection and two further inspectors carried out desk top review of evidence which included speaking with staff by telephone. An Expert by Experience contacted people's relatives by telephone to gain their feedback. 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
Willow Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had no manager registered with the Care Quality Commission. An interim manager had been appointed. This means that the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

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, including information

from the provider about important events that had taken place at the service, which they are required to send us. We sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with two people who lived at the home about their experiences of the care provided. We spoke with seven members of staff including the manager, a senior carer and the maintenance person. We also spoke to one of the directors. We reviewed a range of records. This included four people's care records, multiple medication records, two staff recruitment records and we looked at a variety of records relating to the management of the service. We walked around the building to observe the environment.

After the inspection
We continued to seek clarification from the manager and the director to validate evidence found. We looked at training data and quality assurance records and sought feedback from health and social care professionals. We made referrals to the local fire authority and the local authorities' safeguarding and public health departments.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) and regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements had been made at this inspection and the provider was still in breach of regulation 12 and 15

● The environment and systems in relation to fire safety had not been upgraded by the provider following our last inspection in April 2019.
● Informal checks of the building and equipment safety were not always completed. For example, in relation to fire doors, bedroom lighting, hoisting equipment, the passenger lift, infection control and profiling beds.
● The providers audit process did not include a system to ensure such checks were completed therefore, safety issues had been left unnoticed.
● The provider failed to protect people from the risk of harm in relation to falls. One person had sustained injuries from multiple falls and their risk assessment and care plan had not been updated to show how they would be protected. On one occasion they were left unattended by allocated one to one support staff and subsequently had a fall, the provider did not demonstrate action taken to respond to this incident or lessons learnt.
● The provider did not ensure analysis of accidents and incidents to identify patterns and trends. This meant incidents often reoccurred or escalated.
● Incident records showed multiple occurrences when staff had physically intervened and 'removed' a person who lived with dementia away from a situation were staff believed they where at risk of harm. Their care plans and risk assessment did not outline positive strategies to minimise distress to the individual in the least restrictive way or how to protect staff and other service users when they became distressed.
● We found staff did not always ensure people newly admitted to the service were sufficiently risk assessed. One person's pre-admission information showed they had risks associated with nutrition, diabetes, mobility, falls, distressed behaviours and skin integrity these had not been assessed on admission or during their initial stay.

Systems and processes to safeguard people from the risk of abuse
● Staff failed to follow safeguarding processes for a number of unexplained injuries, near misses and

incidents that caused people to sustain serious injuries.
● Staff had not been provided sufficient training in safeguarding adults.
● The provider failed to follow the Local Safeguarding Authority's protocol to assess incidents for safeguarding purposes and staff were not familiar with the protocol.

Safeguarding processes were either not in place or robust enough to demonstrate people were protected from the risk of abuse. This placed people at risk of harm. 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.

Using medicines safely
● Information about people's 'when needed' medicines were not sufficiently recorded to ensure staff responsible for the administration of medicines had clear directions. For example, two people prescribed sedative medicines for agitation were regularly administered their treatment without known cause or need. We could not be sure the medicines were given because they were needed or if the administration had become routine practice. Staff did not record what strategies had been considered before use of sedative medicine and the effects of the medication were not adequately monitored or reviewed.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to ensure people's when required medicines were managed in a safe or effective way. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● The provider failed to effectively protect people from the risk of Covid-19 and other infectious disease. People who lived at the service had not been tested for Covid-19 in line with government guidelines for care homes, the manager told us they had failed to ensure people's person-centred needs were considered before a whole home approach to discontinue testing had taken place in October 2020, this was ongoing up until the time of the inspection.
● After the inspection the manager confirmed they had taken steps to individually assess people's need and preferences in relation to testing for Covid-19.
● The provider failed to ensure the environment was sufficiently clean and well maintained. Infection prevention and control processes were inadequate. For example, staff did not have access to a suitable area to put on and take off personal protective clothing and sluice rooms were cluttered and not fit for the purpose of dealing with clinical waste.
● The majority of people did not have access to oral care equipment including toothbrushes and toothpaste. We found some toothbrushes had been stored in a communal cupboard and were not identifiable. Most of the people who lived at the service relied on staff to support them with oral hygiene.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to ensure people were protected from Covid-19 and other infectious disease. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They provided evidence of immediate improvements and compliance with guidelines for the management of Covid-19 in care homes.

We have also signposted the provider to resources to develop their approach.

Staffing and recruitment

● The provider had systems in place for safe recruitment but these had not been consistently followed. We found two new starters had employment gaps which had not been fully explored. The manager acknowledged this and assured us they would amend the recruitment process to ensure immediate improvements were made.

● People's representatives and staff told us there were sufficient numbers of staff deployed. Staffing rotas were generated in advance and any gaps were covered by agency staff who were known and had regularly worked at the service.

Inadequate

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- The provider failed to ensure staff had the right skills and competencies to meet people's needs and safely support them. For example, staff had not received sufficient training in practical moving and handling, fire safety, safeguarding vulnerable adults, mental capacity, dementia care and Infection prevention and control.
- Staff were supporting people who displayed distressed reactions on a frequent basis. The provider failed to ensure staff were trained and supported to ensure effective and safe care was delivered. We found examples of staff undertaking restrictive practices without specific training to do so in a safe way.

Systems were either not in place or robust enough to demonstrate sufficient training and support for staff. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed training had been scheduled.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet

- Staff did not ensure people were consistently risk assessed or supported in a person-centred way or in line with best practice standards to gain positive outcomes. For example, people who lived with dementia and experienced distressed reactions or impaired ability to communicate had not been assessed in a person-centred way. Staff did not use dementia assessment tools when considering the use of sedative medicines for the management of people's behaviour.
- Staff did not ensure people were consistently assessed for the risk of weight loss or weight gain. For example, one person's nutrition assessment and weight record has not been fully completed for seven months. Their weight chart showed they had lost 4kg however, the rest of the nutritional assessment was not completed to establish what this meant for the individual. We observed the person whilst they ate breakfast and staff confirmed they took excessive time to eat and therefore often only ate small portions. This need was not incorporated into the person's nutritional care plan or risk assessment and placed them at risk of malnutrition.

Systems were either not in place or robust enough to demonstrate effective assessment and support for people who lived with dementia and other health care needs. This was a breach of regulation 9 (Person-

centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● The provider failed to ensure people were consistently assessed in line with principles of the MCA and associated DoLS. For example, a blanket decision had been made in October 2020 by the manager to withdraw all people who lived at the service from Covid-19 testing. This decision had not been assessed on an individual basis or in accordance with the MCA. People supported by staff on a one to one basis had not been assessed in line with DoLS despite them being under continual control and supervision.

Systems were either not in place or robust enough to demonstrate compliance with the MCA and DoLS. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● The environment was not designed to meet the needs of people who lived with dementia. The environment was not stimulating and did not help orientate people to their environment to promote independence. People's bedrooms were not always personalised to demonstrate a person-centred approach.

We recommend the provider consults national best practice guidance around creating a safe and effective dementia friendly environment.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People's care records showed inconsistent engagement with external health and social care professionals. We received positive feedback from a visiting professional who informed us staff worked well with them and updated them when people's needs changed. However, we also found examples in people's care records when staff had failed to escalate or report significant incident including unexplained bruising and repeated falls.

Inadequate

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider failed to assess and monitor the quality and safety of the service provided and to mitigate risks relating to the health, safety and welfare of people who lived at the home. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The provider and manager failed to ensure the service was well-led. There was a lack of understanding about quality performance and regulatory requirements. The provider failed to quality assure the service therefore, shortfalls found at this inspection were not already known or acted on.
● Systems for learning from incidents and near misses had not been adequately implemented. This meant staff could not demonstrate whether they had reviewed what could be learnt from incidents and events to reduce re-occurrences. People were at risk of harm because their safety and welfare had not been adequately assessed.
● The provider failed to submit statutory notifications after serious incidents had occurred. This meant that CQC could not undertake its regulatory function effectively.

This was a potential breach of regulation 18 (Notification of other incidents) of Care Quality Commission (Registration) Regulations 2009.

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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People's care records showed inconsistencies in duty of candour processes. One person had fallen multiple times and sustained injuries. The manager and staff failed to safeguard the individual in line with the local safeguarding authority processes which meant duty of candour processes had not been effectively fulfilled.
● People did not consistently receive person-centred care. We found examples where people had not achieved good outcomes because staff lacked the knowledge and skills to be able to identify how to keep

people safe. For example, the provider did not ensure accidents and incidents were investigated and risks sufficiently mitigated to protect people from the avoidable harm.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Staff and relatives told us they felt involved with the running of the service. Comments from staff included, "The manager is involved and easy to talk to." and "The manager involves staff."
- Relatives told us, "I like the manager very much he is compassionate and very interested in the residents." and "The senior staff are fine recently started sending emails which is great. The manager is friendly and helpful."

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to adequately assess risk and monitor safety at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure people's care and treatment was in line with principles outlined within the Mental Capacity Act and associated Deprivation of Liberty Safeguards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to adequately assess risk and monitor safety at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure people were effectively safeguarded from the risk of abuse, neglect and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 15 HSCA RA Regulations 2014

personal care Treatment of disease, disorder or injury	Premises and equipment The provider had failed to ensure the premises were adequately maintained and acceptable standards of hygiene were provided throughout the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff received suitable training and support to undertake their roles and responsibilities.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider failed to effectively govern and quality assure the service.

The enforcement action we took:

We served a warning notice.