ADL Plc

The Willows

Inspection report

Willow Drive
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Willows is a residential care home that provides accommodation and personal care to people aged 65 and over, some of whom maybe living with dementia. At the time of this inspection 25, people were living at the service.

People's experience of using this service and what we found
The service has failed to receive a good rating in the last five consecutive inspections. Systems in place had failed to improve the quality and safety of the service. There was insufficient oversight of this service with ineffective quality assurance systems in place which were not identify or driving forward improvements.

There was insufficient staff to meet people's needs and to ensure a safe, clean environment. This meant people had to wait for personal care and were left in communal areas for long periods of time without any staff presence.

Infection control procedures were not effective to reduce the risk of spread of infection during the COVID-19 pandemic. Medicines were not managed safely. Regular health and safety checks had not been carried out and risk management was not effective, placing people at risk of harm.

A lack of oversight of the recruitment processes meant processes were not always robust. Staff did not receive adequate induction, training or supervision to ensure they had the appropriate skills and knowledge to support people. People were not always safeguarded from the risk of abuse and oversight of these systems were not effective.

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. We made a recommendation about this.

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

Rating at last inspection
The last rating for this service was requires improvement (published 14 May 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations. This service has been rated requires improvement for the last four consecutive inspections. This inspection has been rated inadequate.

Why we inspected
We received concerns in relation to safeguarding people, staffing numbers and the administration of

medicines. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. 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.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Willows on our website at www.cqc.org.uk.

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.

We have identified breaches in relation to medicines, assessing risk, infection control, health and safety staffing, safeguarding and governance.

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

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.

Special Measures
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?

Requires Improvement

The service was not always 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.

The Willows

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 attended on the first day of inspection and one inspector returned on the second day of inspection.

Service and service type
The Willows 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 did not have a manager registered with the Care Quality Commission. Having a registered manager means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. A new manager had recently started at the service.

Notice of inspection
The first day of the inspection was unannounced. We told them we would be returning on the second day.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key

information about their service, what they do well, and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
We spoke with the director, the new manager, the covering manager, one senior care workers and the chef.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We continued to seek further information from the provider to support the inspection. We spoke with 10 relatives of people using the service, two care staff and two visiting professionals.

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 now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- People's medicines were not managed safely. One person was being administered medicines without the recommended gap between doses. One person was not being administered medicines they had been prescribed and no one within the service was able to explain why.
- Staff did not always stay with people to ensure they had taken their medication.
- We observed one person being given their medicines covertly, despite having no covert plan in place.
- Staff did not receive regular competency assessments to ensure they were administering medicines in line with best practice.
- People did not have access to their medicines on a night-time as night staff were not trained to administer them. A staff member told us, "They don't have seniors on a night. So, they can't administer medicines like controlled drugs as they have not had the training. People have to wait for seniors to come in to give medicines."
- There was limited evidence that people received medicines which were prescribed for 'as and when required'. Protocols to help guide staff when to administer these types of medicines were not always in place.

Failure to have systems in place for the safe administration of medicines was a breach of regulation 12, (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Care plans and risk assessments were not always in place or had not been updated to guide staff how to deliver safe care and reduce risks.
- Accident and incidents were not always recorded on the appropriate paperwork or reported to the manager. The covering manager did not have an accurate picture of accidents and incidents within the service.
- Health and safety checks had not been carried out which put people at risk of harm should there be an emergency. Regular fire drills, fire extinguisher checks and legionella checks had not been completed weekly in line with their own internal procedures.

The failure to assess and monitor risk 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

We were not assured that the provider was preventing visitors from catching and spreading infections. The visiting room being used was unclean and stored belongings covered in dust.
● We were not assured that the provider was meeting shielding and social distancing rules. People were not encouraged to social distance in communal spaces and there was no risk assessment in place for this.
● We were not assured that the provider was admitting people safely to the service. One person had recently been admitted to the service from hospital and government guidance had not been followed.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. The premises were unclean and unhygienic. Some people's bedrooms had a strong malodour and mattresses and bedding was dirty.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were not assured that the provider's Infection Prevention and Control (IPC) policy was up to date. Policies in place were not up to date and failed to give staff adequate guidance as to the correct action to take.

The provider had failed to ensure effective IPC measures were in place. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were somewhat assured that the provider was accessing testing for people using the service and staff. However, records in place needed to be more robust to ensure this was being monitored effectively.
● We were somewhat assured the provider was facilitating visits for people living in the home in accordance with the current guidance. People's relatives told us they made visits to the service.
● We were somewhat assured that the provider was using PPE effectively and safely. Most staff were observed to be wearing the correct PPE. However, some staff were observed on occasions to be wearing masks down below their chins.

Staffing and recruitment.
● There was insufficient staff to meet people's needs. All staff spoken with, apart from the director, advised there was not enough staff available to support people. One staff member told us, "I have had concerns in the past year about staffing levels, it been horrendous. I am constantly saying, 'I will be back in a min' we can't give them [people] the correct care that you want."
● There was six people who required two staff to support them. Rotas showed, on a night-time, there was only two staff on duty which meant staff were not always available to support other people in the service.
● The provider had a tool to assess the staffing levels and ensure there was enough staff to meet people's needs. This was not accurately completed to reflect the current needs of people. A relative told us, "I do have concerns that there are not enough staff. On one occasion when I visited…it was not safe."
● People were observed throughout the inspection to be communal spaces with limited or no staff presence for long periods of time.

Failure to have sufficient numbers of staff is a breach of regulation 18, (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from the risk of abuse. One person was being restricted within the building by a locked door. This was highlighted by a visiting professional as a safeguarding concern and although action was initially taken to address this, at the time of this inspection this restrictive practice continued.
● People were involved in incidents which should have been logged on a safeguarding log and monitored and/or referred to other agencies such as the local safeguarding authority and CQC. This had not happened.

Failure to safeguard people from the risk of abuse is a breach of regulation 13, (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- There was no competency assessment carried out to ensure staff followed correct procedures in relation to IPC, moving and handling and administering medication. We identified concerns which showed staff required further training to ensure they had the appropriate knowledge and skills.
- The providers training matrix showed staff training was out of date or had not been completed.
- Staff did not receive regular supervision.

The failure to ensure staff received sufficient support, supervision and training is a breach of regulation 18, (Staffing) 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 principles of the MCA were not always followed. For example, people being given their medicines covertly without a capacity assessment or best interest decision in place.
- Restrictive practices were in place without the relevant authorisation or an assessment that this was the least restrictive option.
- Some people had restrictions on their liberty which had been authorised under the DoLS. Records to monitor when renewals were due were not clear.

We recommend the provider review their procedures on the MCA and systems in place to track and monitor

DoLS applications and authorisations.

Assessing people's needs and choices, delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs

- People did not always receive care in line with standards. People did not receive person centred care due to the lack of staffing.
- Assessments were carried out prior to people being admitted to the service.
- Some people's bedrooms had been personalised with their own belongings; however, some people's bedrooms were poorly maintained and not homely.

Supporting people to eat and drink enough to maintain a balanced diet

- People's choice at mealtimes was limited. Only one meal was on the menu, but the chef told us they were trying to accommodate choices where they could.
- There were no menus on display for people to see what was being served.
- Monitoring charts in place to monitor people's food and fluid intake were not accurately completed or monitored.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Access to health professionals and supporting agencies was not always sought in a timely manner. Records showed the home had not been proactive or submitted the necessary referrals to other professionals.
- Communication with relatives regarding healthcare appointments was poor. A relative told us, "The home does not inform me, I only find out how they are by calling them. I have not been informed of any GP visits. I would say they are not proactive."

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 now 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider had failed to ensure the service made the necessary improvements. This is the fifth consecutive inspection the service had not been rated as good.
- There were shortfalls in the way the service was being led, including a lack of oversight by the provider in the absence of a registered manager.
- Audits in place had failed to identify and act on the areas of concern we identified at this inspection.
- Records were not always stored securely. We observed care plans stored in an unlocked cupboard in the manager's office. The manager's office was sometimes left unlocked with no one present.
- There was a failure to manage risks posed to the health, welfare and safety of people. This included safe staffing levels, medicines, IPC and risk management.
- Staff did not keep accurate and contemporaneous records. People's care records were not completed in real time and did not reflect the care and support they should receive.
- The provider had failed to act on feedback to improve the service.

Failure to assess, monitor and improve the quality and safety of the service was a breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider had not always submitted notifications to CQC about events as they are required to do by law.

Failure to notify CQC as required was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This is being followed up outside of the inspection process and we will report on any action once it is complete.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

- People did not receive person centred care due to the poor staffing levels.
- The service did not promote a culture of working with agencies and external partners to meet people's needs.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2) (3). People were not safeguarded against the risk of abuse. There were ineffective systems and processes in place to prevent o address allegations of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) (2) (a). There were insufficient numbers of staff to meet people's needs. Staff were not supported in their role through regular training and supervision.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not always submitted notifications to CQC about events as they are required to do by law.

The enforcement action we took:

We issued a Fixed Penalty Notice and this has been paid by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely. Risks to people were not assessed or mitigated against.

The enforcement action we took:

We issued a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of oversight and systems in place to monitor and improve the service.

The enforcement action we took:

We issued a Warning Notice.