Holt Green Residential Homes Limited

Willow Lodge

Inspection report

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

Summary of findings

Overall summary

Willow Lodge is located in a residential area of Ormskirk, close to the town centre and all local amenities. The home provides support for up to 22 people who require assistance with personal or nursing care needs and who are living with a dementia related condition. Accommodation is available in both single and shared facilities on two floors served by a passenger lift and stairs. There are spacious communal areas available including lounges and two conservatories. There is parking to the front of the property and a garden area to the rear of the home. At the time of our inspection there were 19 people who lived at Willow Lodge Nursing Home.

The registered manager of Willow Lodge had left employment unexpectedly four months prior to 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 of the Health and Social Care Act and associated regulations about how the service is run. The deputy manager had taken on the role of acting manager and was on duty throughout the inspection process.

At the last inspection on 6 December 2016 we rated the service as 'Requires Improvement'. This was because four breaches of legal requirements were found. These were in relation to person-centred care, safe care and treatment, safeguarding service users from abuse and improper treatment and good governance. At that time Willow Lodge was placed in special measures because the area of 'safe' was rated as 'inadequate'. Therefore, we took steps to ensure people were made safe and the provider submitted an action plan detailing the improvements they planned to make. Comments contained in the action plan were considered during this inspection.

We found at this comprehensive inspection on 03 October and 10 October 2017 the provider had met the legal requirements in relation to person-centred care and safeguarding service users from abuse and improper treatment. However, the concerns previously raised in relation to safe care and treatment and good governance had not been adequately addressed. Therefore the provider continued to fail to meet the legal requirements of the regulations in these areas. We also found the provider did not meet the required regulations in relation to fit and proper persons employed. The domains of 'safe' and 'well led' were rated as 'inadequate' and therefore Willow Lodge remains 'inadequate' overall and in special measures.

People who lived at Willow Lodge told us they felt safe being there. Fire procedures were readily available, so that staff were aware of action they needed to take in the event of a fire. However, we found parts of the environment to be unsafe and the management of medicines was poor. There was no evidence available to demonstrate all systems and equipment within the home had been appropriately serviced to ensure they were safe and fit for use. Records were not available about how people needed to be assisted from the building, should evacuation be necessary. Therefore, this was a continuous breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that quality monitoring systems had been implemented, but these were not always effective, particularly in relation to medicines management, care planning, recruitment and safety and suitability of the premises. The plans of care were in general well written documents. However, the ones we saw had not all been reviewed and updated to reflect people's current needs. Although the provider was aware of this; action had not been taken to address these failings. Therefore, this was a continuous breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment practices adopted by the home were poor. Appropriate background checks had not been conducted, which meant the safety and well-being of those who used the service was not adequately protected. There was no evidence on the staff personnel records that induction programmes had been completed by new employees. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Business continuity plans were in place, should evacuation be necessary. However, key staff had not received training in this area. We made a recommendation about this.

We noted that attention to detail in relation to the environment was lacking. We made a recommendation about this.

The plans of care we saw were not always being followed in day to day practice and the provision of activities was limited. We made recommendations in these areas.

We saw people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems adopted by the home were in accordance with the principles of the Mental Capacity Act 2005 (MCA). Records showed detailed Mental Capacity Assessments had been conducted before applications to deprive someone of their liberty were submitted. However, relevant documentation was not retained for those who had legal authority to act on a person's behalf. We made a recommendation about this.

The acting manager had notified us of any significant events, such as deaths, safeguarding referrals and serious incidents.

We found the risk assessment process in relation to health and social care was satisfactory and systems for the recording of safeguarding incidents had been implemented. The staff team had received training in safeguarding adults and whistle-blowing procedures. Staff members we spoke with were confident in making safeguarding referrals, should the need arise.

We noted there was always a staff presence within the communal areas of the home and people looked comfortable being with staff members. We observed some good interactions between staff and those who lived at Willow Lodge and we found people's privacy and dignity was, in general respected throughout the day. Staff members were seen to be kind, caring and compassionate.

Where agency workers were used, then these were often the same members of staff, which helped to promote continuity of care and support.
Records showed supervision sessions for staff were completed, although these could have been more structured. Annual appraisals had not been implemented. We made a recommendation about this.

Staff told us they received effective training and they gave some good examples of learning modules, which they had completed. Certificates of training were retained on the personnel records we saw. However, the

training matrix did not match this information. We made a recommendation about this.

Meal times were pleasant and relaxed and people we spoke with were complementary about the staff team. They felt they were treated in a kind, caring and respectful manner. People expressed their satisfaction about the home and the services provided.

People we spoke with were aware of how to raise concerns, should they need to do so. A complaints procedure was in place at the home and a system had been implemented for the recording of complaints received. The service worked well with a range of community professionals. This helped to ensure people's health care needs were being appropriately met.

Regular meetings were held for the staff team. This enabled those who worked at the home to discuss topics of interest in an open forum. People's views were also gained through processes, such as satisfaction surveys. However, we made recommendations around the provision of meetings and gathering feedback about the quality of service provided.

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.

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

This service was not safe.

Recruitment practices adopted by the home were poor. New staff had not received formal induction and relevant checks had not been completed before staff members started to work at the home.

Although some improvements had been made to the environment, there were many areas which were unsafe and needed to be addressed.

Health and social care risk assessments had been conducted. However, medicines were not being well-managed.

Safeguarding referrals had been made to the relevant authorities. However, Personal Emergency Evacuation Plans were not in place.

Staff members were aware of the procedures to follow should they have concerns about the welfare of those who lived at the home.

Is the service effective?

Requires Improvement

This service was not consistently effective.

Training was provided for staff, but the training matrix was not up-to-date. Supervision sessions were arranged, but these were not structured and annual appraisals were not being conducted.

Mental capacity assessments had been conducted, in accordance with the Mental Capacity Act. Deprivation of Liberty Safeguard approvals had been requested, where necessary. The information recorded was very detailed.

Meal times were being well managed.

Is the service caring?

Good

This service was caring.

Staff were seen to be kind, caring and respectful of people's needs. Those who lived at Willow Lodge were supported to access advocacy services, should they wish to use this service.

Records were retained in a confidential manner and people's privacy and dignity was respected.

Those who lived at the home were supported to maintain their independence, as far as possible and staff members communicated well with those in their care.

Is the service responsive?

Requires Improvement

This service was not consistently responsive.

We found the care plans and risk assessments were often linked in order to promote a holistic approach to care. However, two plans of care we saw did not accurately reflect people's current circumstances.

The provision of activities was limited. There was no evidence to show that staff supported people to maintain their individuality and to participate in a choice of activities.

Complaints were being well managed.

Is the service well-led?

Inadequate

This service was not well-led.

The home had developed systems for assessing and monitoring the quality of service provided. However, the auditing system had not consistently identified areas in need of improvement.

A wide range of policies and procedures were in place. Feedback was sought from those who used the service. However, feedback had not been gathered from staff members or community professionals.

Meetings for the staff team were evident, but not for those who lived at the home or their relatives, although an open door surgery had been arranged.

Willow Lodge

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Willow Lodge is a 'care home'. People in care homes receive accommodation and nursing care as single under one contractual agreement. CQC regulates both the premises and care provided. We looked at both during this inspection.

Willow Lodge is situated near the centre of Ormskirk, with all amenities close by. The home provides both single and shared room accommodation for up to 22 adults who are living with a dementia related illness and who need assistance with personal and nursing care. Accommodation is provided over two floors; the first floor being served by a passenger lift and stairs. There are spacious communal areas available including lounges, dining areas and two conservatories. There is parking to the front of the property and a garden area to the rear of the home.

This inspection visit took place on 03 October and 10 October 2017. The first day was unannounced. The acting manager was given short notice of the second day of our inspection. This was so that she could be available to provide the information we needed to see.

The inspection activity started on 01 October 2017 and ended on 10 October 2017. It included reviewing the service's previous inspection report and notifications, which the provider is required to send to us by law about important things that have happened. These included accidents, deaths and safeguarding incidents. Prior to our inspection visit we contacted the commissioning department at Lancashire County Council and Healthwatch Lancashire. Healthwatch is an independent consumer champion for health and social care. This helped us to gain a balanced overview of what people experienced when using the service. We also looked at the information we had received from other sources, such as community professionals involved in the care and support of those who lived at Willow Lodge Nursing Home.

At the time of our inspection there were 19 people who lived at Willow Lodge. Due to those who lived at the

home being affected by dementia related conditions, it was not possible to converse with many of them. However, we were able to gather feedback from four people who lived at Willow Lodge and three relatives of those who used the service. In addition we spoke with three members of staff and the acting manager of the home.

We looked at care records of five people who lived at Willow Lodge. We also looked at three staff personnel files to establish the quality of recruitment practices, staff training and supervision. We assessed the arrangement for meal provision and the management of medicines. We also looked at records relating to the management of the home and how staffing levels were calculated. In addition we checked the building to ensure it was clean, hygienic and a safe place for people to live.

We toured the premises, viewing all communal areas and private accommodation with permission. We observed the day-to-day activity within the home. During our inspection, we used a method called Short Observational Framework for Inspection (SOFI). This involved observing staff interactions with people in their care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk.

The inspection team consisted of two adult social care inspectors and a medicines inspector from the Care Quality Commission. The provider had completed and submitted a Provider Information Return (PIR) prior to our last inspection six months previously. We therefore did not request another to be submitted on this occasion. A PIR is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Willow Lodge. We received some positive responses about the staff team. One person said, "The staff are just great. They are really nice." A relative commented, "[Name] is treated well. I don't have any concerns."

At our last inspection we found that risk management plans, in relation to health and social care were not always in place and where risk assessments had been conducted, they had not been reflected within the plans of care. This meant that staff may not have had all the necessary information to support people in a safe manner.

At our last inspection we also judged the management of medicines to be unsafe. People were not receiving their medicines as prescribed, which could have potentially had a serious detrimental impact on those who missed their medicines.

The above findings constituted a continuous breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found detailed health and social care assessments had been conducted within a risk management framework, which provided clear guidance for staff about action that needed to be taken in order to reduce the risk of harm.

At this inspection a medicines inspector from the Care Quality Commission looked at whether medicines were managed safely in the home. We looked at records about medicines and arrangements for ordering and storing medicines. At the last comprehensive inspection in April 2017, the registered manager felt that the electronic administration system was hindering safe medicines management. The system had been changed back to paper records, but we still found that medicines were not always being handled safely.

The treatment room was accessed via a key coded door that was not secure and medicines requiring refrigeration were not stored securely, because the fridge was not locked at the time of our inspection. Regular temperature monitoring was carried out to make sure the fridge was within the required range.

One person required a thickened fluid to take their medicine, because they had difficulty swallowing. A care worker prepared the drink, which was not to the required consistency. The thickener powder was not documented on the Medication Administration Record (MAR), as it should have been. We found that an additional two people, who were receiving thickened fluids, did not have thickener recorded on their MAR charts. Staff confirmed that although drinks were recorded, they did not document when a thickened drink was given to any person who lived at the home. This meant that people could be in danger of choking if thickened fluids were not prepared correctly.

During the medicine round, the medicines inspector highlighted an error to the nurse, who was intending to administer one tablet instead of the prescribed two to one person who lived at the home. This was

corrected and the prescribed dose was given.

We looked at the MAR charts for all 19 people who lived at the home and examined seven in detail. Two people did not have photographs on their charts. A photograph of people on the MAR charts helps to identify them and therefore reduces the possibility of medicine errors. Nine people did not have any allergy status recorded and two had conflicting information documented on different pages of their MAR charts. For example, one page stated that the person had an allergy to penicillin and the following page recorded 'no known allergy'. People could be at risk if they are given something they are allergic to.

We found medication administration errors on four of the MAR charts we checked. Poor recording practices meant that one person had received two doses of paracetamol too close together on two days during October. Paracetamol should be administered with a four hour gap between doses. One person had been given paracetamol two hours apart and another one hour and twenty minutes apart. A medicine used for agitation had also been given to one person and not recorded properly.

Another person had been given a medicine that was not written on their current MAR chart twice in October. Administration had been recorded on the carers medication note, but no clear directions were available to give the medicine safely. Another person had received a medicine twice on the same day, when the administration record stated 'give one daily when required.' A medicine that should have been given at the same time each day was administered three hours earlier than stated on the label each night. Staff confirmed that the instructions on the label and MAR chart were not followed. A cream had been written incorrectly on the MAR chart and the name of the medicine did not match the cream in the trolley.

Four people had medicines prescribed 'when required.' No information or guidance was present in their MAR chart on when to administer the medicines, to ensure staff administered them in a consistent and timely way. One person was prescribed a medicinal patch to be applied to the skin daily, but there was no record of where the patch had been applied on the body. This is important to reduce the risk of skin irritation caused by repeated application to the same area.

The acting manager could not provide us with evidence that staff had been assessed as competent to administer medicines. Monthly medication audits (checks) had not been regularly undertaken and the two audits we saw had not highlighted the issues we found during the inspection.
The above findings constituted a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the safe administration of medicines.

During the course of our inspection we toured the premises and found that although some refurbishment had been completed, there were still areas which needed attention in order to keep people safe. For example, we saw a half stable door in the ground floor corridor, which was dangerous, as it had very sharp, jagged hard plastic edges and exposed protruding nails. One hand-wash basin in a toilet facility on the first floor was coming off the wall. We noted that there was rubbish in the corner of one bedroom that was occupied by a person who used the service. These included a piece of carpet, a block of wood and several plastic ties. In another bedroom the head of the bed was tilted and an exposed loose wire was over the bed head. These observations were addressed once we brought them to the attention of the acting manager.

We also noted that the small bolts on the half gates on the stairwell were ill fitting and difficult to open or close. This could place people at risk, should evacuation be necessary. One radiator cover was loose and there was a hole in another. Some bedroom doors slammed shut and could therefore result in entrapment, causing injury. The door of a store cupboard did not fit into the door frame properly. A tall wardrobe in one bedroom was light in weight and could have easily tipped over, as it was not secured to the wall. The bed

rail cover did not fit the bed rail properly in another bedroom. One conservatory, which was used as the dining room was in a very poor condition, as the doors and windows were insecure, despite being taped up. The window and door handles were broken in this conservatory and the glass was dirty and mouldy.

We asked the acting manager for a random selection of service certificates, but these were not all available. The acting manager was unable to provide portable appliances testing, safety of hoists, landlord's gas safety, servicing of the electrical installation and operation of the fire alarm system. This put people at risk of harm, due to systems and equipment being potentially unsafe for use. The service certificates for the electrical installation and hoist safety were subsequently provided by the provider. However, these were not available on site at the time of our inspection. We noted a wheelchair and sit on weighing scales to be stored in a corridor beneath a sign, which clearly read, 'Keep clear of clutter, as a fire door'. This put people at risk of harm, should evacuation be required. Records were not available about how people needed to be assisted from the building, should evacuation be necessary.

We observed a nurse administering medicines to one person in their bedroom. The medicine trolley was kept locked whilst it was left in the lounge, but it was placed in front of a fire exit during the administration of medicines, which could have potentially restricted access if the exit was required in an emergency situation.

The above findings constituted a continuous breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received feedback from one community professional who wrote, 'We have nothing but positive feedback with regards to Willow Lodge Nursing Home. We have found them to be professional on all aspects. We have regular meetings with the manager and with consent communication with regards their residents and their medication. From a Pharmacy prospective all medication is ordered on time by the Nursing Home and medication is checked in by the home with a prompt response of any changes to medication. I personally have visited Willow Lodge a handful of times without an appointment. I have found the staff very helpful and friendly but most of all I see them interacting with their residents. It is a pleasure dealing with such a lovely family business that is passionate about the care they give.'

At the last inspection we found there were a high number of incidents between people with challenging behaviours which had impacted on other people who lived at the home. Safeguarding referrals had rightly been made by the home and other professionals had been involved in the care and support of these people. However, safeguarding records were not robust and high risk behaviours were not fully described or risk assessed in the care plans. This meant that people who used the service were not always protected from abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that systems had been introduced for recording any safeguarding referrals and the outcome of each incident reported was clearly documented. We asked staff about their understanding of safeguarding. Staff members were aware of the procedures to follow should they have concerns about the welfare of those who lived at the home and were confident to raise safeguarding concerns, should they need to do so. Therefore, the breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met on this occasion.

At this inspection we found recruitment practices to be poor. We looked at the personnel records of three staff members. The records for the first staff member did not contain a completed application form. There were no references available and there was no evidence to show that a Disclosure and Barring Service (DBS) check had been conducted. A DBS is to check if the applicant has any convictions and then the provider can

make an employment decision. There was no induction record within this staff members file and no appraisal had been conducted, despite this person having worked at the home for over eighteen months. The second staff member's personnel file contained two written references. However, both these references had been sought for the person working as a care assistant and not in the role they were employed for. Therefore, these were ineffective. This person's application form was blank, except for their personal details on the front sheet. There was no evidence that a DBS had been sought. There was no induction record or appraisal on this staff members file. There was no application form or references on the third staff member's record. There was no evidence of an induction when they commenced employment and no appraisal. This was concerning as we were told that this particular member of staff was being formally monitored due to poor work performance.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager talked us through the recruitment practices she had implemented for the last prospective employee. This person had not been allowed to commence employment at the time of our inspection because all recruitment checks had not been received. The acting manager was in the process of implementing robust recruitment practices.

We spent some time in the communal area of the home and noted that there were sufficient staff on duty to meet the needs of those who lived at Willow Lodge. Staff were always present in the lounge and communicated well with those in their care. We looked at the amount of hours covered by agency staff and found that although agency staff were used, the same staff often worked at the home. This helped to promote continuity of care. We observed one agency care worker interacting well with those who lived at the home, providing them with beverages of their choice and assisting them with activities of daily living, in a pleasant and compassionate manner.

We observed staff members transferring people and helping them to mobilise on several occasions. These manoeuvres were always conducted in a safe and competent manner, whilst good explanations were provided to the individual being assisted, with reassurance, encouragement and praise being offered throughout.
Staff we spoke with gave us some good examples of training around safety, which they had completed. These modules included health and safety, moving and handling, first aid, dementia awareness, safeguarding vulnerable people, mental health and first aid.

Accident and incident records were maintained appropriately in line with data protection guidelines. This helped to maintain confidentiality and protect people's personal details. During the course of our inspection we noted the emergency buzzer being activated. We observed a rapid response by the acting manager and her staff team. This demonstrated efficient team work.

A fire risk assessment had been conducted and records showed that internal fire alarm tests were carried out each week. An emergency grab bag was available in the reception area of the home, which contained essential items, should evacuation be necessary. The contents of this were checked each month and were replenished if used.

A business continuity plan was in place, which outlined what action staff needed to take in the event of an emergency situation arising. These included gas leak, power failure, flood, fire, adverse weather conditions, explosion, natural disaster, pandemic, epidemic or utility disruption. This helped to ensure that people were protected from harm. However, the business continuity plan stated, 'Training will be given to all staff at the

appropriate level in the implementation and operation of the business continuity plan and emergency protocol procedures'. We established that such training had not been provided for key personnel. The acting manager informed us that she had not received this training and she was not aware of the training being organised. We recommend this training is provided for staff, so that they are aware of action they need to take, should the business plan need to be invoked.

There was an infection control policy in place with good information for staff about the correct use of Personal Protective Equipment (PPE). We noted that PPE and clinical waste receptacles were provided. Clinical waste was being disposed of in the correct manner. An infection prevention and control champion had been appointed from the staff team. This helped to ensure that any relevant information in relation to infection control procedures was implemented and disseminated amongst the staff team. The home was being supported by the infection prevention and control team from the clinical commissioning group. An action plan had been developed, which was being worked through in order to make the necessary improvements.

We established that there were issues around the supply of hot water to some rooms. However, we were told that a plumber had been arranged and subsequently we were notified that the hot water problem had been rectified.

Requires Improvement

Is the service effective?

Our findings

One relative we spoke with told us, "[Name] seems quite content. He is used to who is around him now."

Information was readily available for the staff team about various medical conditions, which affected people who lived at Willow Lodge. Staff told us that they received effective training and they gave some good examples of learning modules, which they had completed. Certificates of training were retained on the personnel records we saw. These covered learning modules such as, moving and handling, pressure care, infection control, fire safety, virtual dementia awareness, mental capacity and Deprivation of Liberty Safeguards. However, the training matrix did not match this information and therefore it was not up to date. We recommend that training records are brought up to date to demonstrate a knowledgeable and skilled workforce is established.

Records showed that employees received supervision, although these could have been more structured and there was little evidence of annual appraisals taking place. This meant that staff members were not always afforded the opportunity to discuss their work performance and training needs with their managers. We recommend that formal, structured supervision sessions and annual appraisals are introduced, in order to support staff and allow them the opportunity to discuss any areas of concern or difficulties experienced, so that any issues could be addressed promptly.

During the course of our inspection we toured the premises and found that some areas of the environment had been upgraded and modernised. However, a lot of the furnishings were mismatched and in need of replacement, as they were old, broken and shabby. Attention to detail in relation to the environment was lacking. For example, wall paper was peeling off below one hand-wash basin, a lamp shade was hanging off the fitting in one bedroom, some pictures on the walls were not straight, some clocks had stopped, others were set at the wrong time and curtains were hanging off their tracks. We recommend that a full audit of the fittings and furnishings be conducted and matching replacements be provided as necessary.

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. The application procedures for this in care homes and hospitals are 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 were being met.

A policy was in place at the home in relation to the MCA and DoLS. We found that decision specific mental

capacity assessments had been conducted before DoLS applications were submitted and these contained good detail. Correct steps had been taken to make DoLS applications where appropriate. We found that a good amount of relevant information had been recorded, with restrictions in place being clearly outlined. However, where care files showed that someone had legal authority to act on a person's behalf, as Lasting Power of Attorney (LPA), the relevant legal documentation had not been retained, in order to support this information. We recommend that legal documentation is retained on individual care files for those who have legal authority to act on a person's behalf.

We noted that where people were unable to make specific decisions because they lacked the capacity to do so and where a legal representative had not been appointed, then discussions had been held between relevant parties to ensure that decisions were made in the individual's best interests.

We looked at the care records of five people who lived at the home and found that consent to care and treatment had been considered. We observed people being offered choices throughout the day.

At the front of some people's care records we saw 'Do not attempt Cardio-Pulmonary Resuscitation' orders. These had been completed by GP's following best interest decisions, involving care staff and relatives. The reasons why such decisions had been made were clearly recorded and options selected about the decision needing to be reviewed or if it was an indefinite decision and therefore not requiring a review date.

We were told that the menus were being reviewed in response to feedback from people who lived at the home and their relatives, in relation to choices and variety. We observed the food service at lunch time and saw that people were shown the two meal options, so they could select which one they preferred. People appeared to enjoy the food served, which looked appetising and nutritious. Were one person was struggling to eat their lunch we saw staff did not respond promptly to support them to eat safely. Staff assisted people to eat in the dining and lounge areas, supporting people to maintain their dignity by sitting with them and using protective clothing when needed.

Some people were provided with metal cutlery at lunch time, whilst others were supplied with coloured melamine crockery and cutlery. The coloured implements were contrasting to the dining tables and therefore this enabled people who were living with a dementia to maintain more independence at meal times. A selection of cold beverages was offered during lunch, but no hot drinks were available at that time. We recommend that people are given the opportunity to have both hot and cold beverages with their meals, should they wish to do so.

On the day of our inspection the permanent cook was not on duty. We spoke with the senior care assistant who was preparing the meals. They told us that they had received a handover from the cook the previous day, who had done as much preparation as possible. We discussed people's nutritional requirements with the temporary cook. They were fully aware of people's special dietary needs and preferences. We noted that people were offered a variety of hot and cold drinks with a selection of biscuits during the afternoon and we were told that snacks were available in-between meals if they wanted something else to eat.

The kitchen area was clean and hygienic with a sufficient stock of food being available. Opened foods were appropriately labelled with disposal dates. This helped to keep people free from eating contaminated food.

Good

Is the service caring?

Our findings

Everyone we spoke with was satisfied with the care and support provided at Willow Lodge. One person said, "The staff are very nice. I am happy here. I wouldn't want to go anywhere else."

There were 19 people who lived at the home at the time of our inspection. We spoke with four of them and three relatives, who provided us with positive feedback about the level of service they received and the caring attitude of the staff team. The home had achieved the 'six steps to success' training. This is a programme which supports staff to develop their roles around end of life care.

Information was readily available in the entrance about safeguarding people and advocacy. An advocate is an independent person, who helps to ensure decisions are made in people's best interests. We noted that a request had been submitted on behalf of one person for input from an Independent Mental Capacity Advocate (IMCA), in order to support with best interest decisions and we were aware that support had previously been provided by IMCAs when needed.

During our inspection we observed people receiving support throughout the day. We saw that staff interacted with people in a pleasant and kind manner and approached them with dignity and respect. Staff we spoke with had a good understanding of people's needs and seemed to know them well.

We observed that people appeared comfortable and relaxed in their surroundings. Everyone looked well presented. We overheard staff members speaking with people in a respectful manner and saw them knocking on bedroom doors before entering. The plans of care we saw incorporated the importance of protecting people's privacy and dignity, particularly during the provision of personal care. However, we observed one incident, in which a member of staff was assisting one person who lived at the home, but at the same time was distracted by another person. This resulted in one person's privacy not being fully promoted. This was unintentional and we were confident it was a one off situation.

Staff members supported people to maintain their independence as far as possible. Good guidance was provided for the staff team, in relation to people's care and support and how to promote people's independence. The care records of one person who lived at the home showed how the staff team had managed their specific needs in order to protect the person's dignity.

Relatives we spoke with were very complimentary about the attitude and approach of staff members who were supporting those who lived with dementia. They (The relatives) described them (The staff) as, 'caring', 'approachable' and 'pleasant'.

One community professional told us, "In my opinion Willow Lodge Nursing home have a very good team of staff members who look after their patients with care and attention. They are very effective when liaising with my medical team. However, when I have visited the Nursing Home I have noted at times it looks overcrowded. Overall I am happy with the services that they offer." Another wrote on their feedback, 'I am pleased to say that we enjoy an excellent relationship with Willow Lodge Nursing Home. Many of our

patients are residents there and we find they are well looked after and requests for visits and medications are appropriate. Our patients appear to be clean and well cared for when we visit and they particularly excel with end of life care in patients with dementia.'

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found that the care planning process did not always reflect people's needs and systems were not always in place to monitor and prevent risk. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we 'pathway' tracked the care and support of five people who lived at Willow Lodge. Pathway tracking is a system we use to ensure people are receiving the care and support they need.

The plans of care we saw varied in quality. Three of them contained a good amount of detail and the plans of care were well written person centred documents. This provided staff with clear guidance about people's needs and how these needs were to be best met. We found these care plans and risk assessments were often linked in order to promote a holistic approach to care. The other two plans of care we saw did not accurately reflect people's current circumstances.

The care records for one person indicated that they needed to wear spectacles. However, we did not observe this person wearing them at any time during the day or at lunch time. This meant that staff were not always being responsive to this person's assessed needs. We recommend that plans of care are always followed in day to day practice.

However, whilst care planning was not always reflective of the current needs of those we pathway tracked, our observations of care interactions throughout the inspection were positive. Staff understood the needs of people they cared for. We found that information throughout the care plans held a good standard of person centred detail. One person's care plan told a story about their current preferences, education, family connections and past employment. Therefore, Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was met on this occasion.

The care plans we viewed contained evidence that a pre-admission assessment had been carried out prior to a person being offered a place at the home. It was evident that information had been gathered from a variety of sources, which helped to develop the plans of care in a structured way. This helped the staff team to ensure they were able to provide the care and support required before people moved into Willow Lodge.

The care records of another person who challenged the service were detailed and clearly identified a wide range of possible triggers. This record provided the staff team with clear guidance on de-escalation techniques for this individual. This helped to keep this person safe.

Evidence was available to show that the service worked effectively with external professionals, such as community health care workers and social workers. This helped to ensure that the health and social care needs of people were being appropriately met. Staff members who we spoke with were able to easily discuss the needs of those in their care and how these needs were to be best met.

We looked at the provision of activities and found that these were somewhat limited. We noted that an

activity coordinator worked at the home two days each week, which was not sufficient for those who were living with dementia, some of whom challenged the service. The activity records we saw had not been completed since May 2017 to date, except for one day in September 2017.

On the day of our inspection we spoke with the activity coordinator, who told us that some people had watched a film and a couple had been supported to do a jigsaw during the morning. We noted that these people were continuing with the jigsaw during the afternoon, although neither person looked to be actively involved in this activity. We saw another film was put on during the afternoon period.

We saw very little activity taking place and people were sitting around the communal areas, many of whom were dozing on and off. Although we did see staff members chatting with people we did not observe people being offered the opportunity to participate in either group or individual activities. We recommend that the provision of activities be increased and reviewed in accordance with people's individual interests and preferences.

Staff presence in communal lounge areas was noticed throughout our inspection. We noted that people were supported to maintain contact with family and friends and we observed visitors coming and going without any restrictions.

People we spoke with were confident in making a complaint, if they needed to do so, or they would ask a relative to support them in doing so. A complaints policy was in place at the home. This included specific time frames to expect during an investigation. A system was in place for recording any complaints received.

Inadequate

Is the service well-led?

Our findings

The deputy manager had taken on the role of acting manager and the responsibility for the day to day operation of Willow Lodge, since the registered manager had left employment unexpectedly four months previously. At this inspection the acting manager told us that she felt supported by the provider, who visited the home at least once a week. She did tell us that she was given some protected hours, so that she could complete managerial duties.

At our last inspection we found that although quality monitoring systems had been implemented these did not include action plans and they were not always accurate. Therefore, this was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that systems to assess monitor and improve the quality and safety of services provided had not been adequately established. A range of audits and risk assessments had been conducted, but these were not always effective, particularly around care plan reviews, medicines management, recruitment and safety of the premises and equipment.

We looked at the care files of five people who lived at the home, two of which had not been updated to reflect people's current needs when their circumstances had significantly changed. For example, we observed one person in a semi-recumbent position in a recliner chair, with a lap belt in place. We looked how their care and support was being provided. This individual's needs had changed considerably. Their care records had not been updated to reflect the current situation. For example, the one page profile stated, 'I will wander around the home, but I like to stay close to staff for reassurance.' The mobility care plan was last reviewed on 19 May 2017 and stated, 'Independently mobile and able to weight-bare. Moves freely in bed and does not require any additional support in this domain.'

The plan of care for psychological needs also referred to this person being fully mobile. This care plan was also last reviewed in May 2017. We spoke with one member of care staff who was supporting this gentleman. They told us that he had not walked for five or six months. We saw a letter on the care file of this person from the Occupational Therapist, dated 25 July 2017, which stated that he needed two people to mobilise and which raised concerns about the recliner chair being a form of restraint. However, a DoLS application had been submitted. This person's needs had changed from him being independently mobile to him being unable to mobilise without the assistance of two people. These changes had not been made in his plan of care. This could have potentially resulted in the provision of unsafe or inappropriate care and support being provided for this individual. However, we did not observe staff attempting to get him up out of his chair and staff we spoke with were aware of his inability to mobilise independently.

The care records of this person also provided some contradictory information. One section identified that they were receiving a diabetic controlled diet, but another section stated, 'normal diet'. This could have potentially resulted in an inappropriate diet being served for the individual.

The recently implemented auditing systems had recognised that plans of care were not all current and

evidence was available to show that some had been updated in accordance with people's needs. However, this plan of care had not been reviewed for five months and action had not been taken to update the information, in accordance with the person's changing needs.

Another person was identified as having a grade two pressure sore. This individual's plan of care stated, 'Due to current pressure area and skin integrity issues she is to receive repositioning pressure relief on an hourly basis day and night, due to reddening of hips.' This care plan was dated 12 January 2017. It had been reviewed monthly from March 2017 to August 2017 and each month it indicated that the information in the plan of care remained valid. However, this was inaccurate and had not been updated in accordance with changes in the person's needs. The skin care plan for one person stated that it should be reviewed every week, because the person was at high risk of tissue damage, but this was not taking place. The turn charts for this person showed that the individual had been repositioned every two hours, rather than every hour, as the care plan instructed. We spoke with the acting manager about this, who confirmed that the plan of care had not been updated, as this person was now being repositioned every two hours and not every hour. Therefore, the plan of care did not accurately reflect this person's current health care needs.

We asked the acting manager for the Personal Emergency Evacuation Plans (PEEPS), but these could not be found. This placed those who lived at Willow Lodge at risk of harm, should evacuation be necessary.

The above findings constituted a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider has made a decision to voluntarily suspend admissions to the home until the necessary improvements have been made.

A wide range of policies and procedures were available at the home. These included areas, such as infection control, fire safety, confidentiality, safeguarding vulnerable adults, health and safety and the Mental Capacity Act and Deprivation of Liberty Safeguards. However, it is recommended that these are reviewed and updated, as needed, as many had not been reviewed for several years. This would help to ensure that current information was provided for the staff team and any other interested parties.

Feedback had recently been requested from those who lived at the home or their relatives about the quality of service provided. Those returned provided all positive responses. However, we recommend that this system be implemented across a broader range of people with an interest in the home, such as staff members and visiting professionals.

Staff meetings were held periodically. This enabled those who worked at the home to discuss topics of interest in an open forum and to raise any issues or comment about areas of good practice, should they wish to do so.

It was evident that relatives and friends were able to visit their loved ones, when they wished to do so and that they were made to feel comfortable whilst at Willow Lodge. However, we established that organised meetings were not arranged for those who lived at the home and their relatives, although an open door surgery had recently been held by the acting manager, which was clearly advertised within the home. We discussed this with the acting manager, who gave us good examples of action taken in response to suggestions made by one relative. We recommend that the management team speak with those who live at the home and their relatives to establish if meetings would be beneficial to them and if so when would be the best time of day for them to attend. Meetings could then be arranged to suit the majority of people. This would allow any important information to be cascaded and would enable people to discuss any topics of

interest in an open forum, should they wish to do so.

Staff members we spoke with told us that they felt well supported and were happy working at Willow Lodge. Comments we received from staff included, "We are like a little family. We work well together" and "When [name – acting manager] says she is going to do something, it gets done. She does seem to get results. She is very fair and looks after her staff. Staff are appreciated and treated well."

The previous inspection rating of 'requires improvement' was clearly displayed in the entrance of the home.

We received feedback from a community professional who told us, 'With regards to Willow Lodge we have some current involvement, in that a quality visit was undertaken. We found a number of areas for improvement and we have been working with the home to help them develop an action plan and prioritise work.'

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured the proper and safe management of medicines. Therefore people were not protected against potential medication errors. The registered person had not ensured that systems and equipment had been appropriately serviced and risks in relation to fire safety had been considered. This meant that people were not protected from harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not ensured that systems were in place, which sufficiently assessed the service, in order to monitor the quality of service provided, particularly around care planning recruitment, medicines and safety of the premises.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person had not ensured that new employees had been recruited properly, in order to ensure they were fit to work with vulnerable adults.