Sequence Care Limited

# Willow Court

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

About the service
Willow Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The service can support up to 11 people who have a learning disability or autism in one adapted building. On the day of the inspection 10 people were living at the service

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. Staff did not always treat people with dignity and respect or speak to them in a way that promoted this.

People were not always communicated with in their preferred way.

Risks to people were not always fully assessed. Guidance and direction to staff on how to minimise risk was not always clear and detailed.

Infection control guidance had not always implemented or followed correctly.

Oversight of the service was not always effective and had not identified the issues we found at this inspection.

People received their medicines safely and as prescribed.

Staff had ad good understanding of safeguarding and knew how to recognise and report abuse. Staff told us they received training and supervision

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 good (published 30 October 2018).

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding. A decision was made for

us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe and well-led.

We reviewed the information we held about the service. No areas of concern were identified in the other key question. 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 coronavirus and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. We found no evidence during this inspection that people were at risk of harm from this concern. Please see the safe and well-led sections of this full report.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Willow Court 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 dignity and respect and good governance at this inspection.

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

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

Details are in our safe findings below.

### Is the service well-led?

**Requires Improvement**

The service was not always well-led.

Details are in our well-Led findings below.

# Willow Court

**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.

Inspection team
The inspection team was made up of one inspector and one Learning Disability Nurse Specialist Advisor.

Service and service type
Willow Court 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 a manager registered with the Care Quality Commission. This 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.

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. We sought feedback from the local authority and professionals who work with the service. 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. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and three relatives about their experience of the care

provided. We spoke with six members of staff including the registered manager, deputy manager and care workers. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included five people's care records and a range of medicine 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 reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Requires Improvement

# 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 good. At this inspection this key question has deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Improvements were required to peoples care plans and risk assessments to ensure staff had the most up to date information to support people in the right way.
- Although staff knew the care and support needs of people, information was not always clear about how to keep people safe. One person with epilepsy did not have an adequate risk assessment to give sufficient guidance to staff on how to support the person.
- Staff had a good understanding of how they should support people. One staff member said, "I was given training about how to look after people. I learnt what triggers people had and knew how to respond when it happened."
- Safety checks were in place for gas, fire, water and electrical safety. Regular health and safety checks were completed on the building and environment to ensure the service was compliant with health and safety regulations

Preventing and controlling infection

- Improvements were required to ensure infection control practices were implemented effectively and in line with government guidelines.
- Most staff wore PPE [Personal Protective Equipment] appropriately throughout the inspection. However, some members of staff wore their mask under their nose or chin which is not in line with current government guidelines and increased the risk of spreading infection.
- Staff were regularly observed not practising social distancing rules with each other as per government guidelines to help reduce the spread of infection.
- The service had introduced additional cleaning schedules which included cleaning of high touch areas.
- Staff told us they had access to personal protective equipment [PPE] and had received training in the use of PPE to prevent the spread of infection.
- During the inspection we signposted the registered manager to resources to develop their approach and implement practices to safely manage infection control and prevention within the home.

Systems and processes to safeguard people from the risk of abuse

- Systems and processes were in place to protect and safeguard people from the risk of possible abuse.
- Relatives told us they believed their family member to be safe. One relative told us, "I think [person] is safe, I'm not worried when I go to bed at night."
- Staff received training about safeguarding people from abuse and whistleblowing and demonstrated a clear understanding of their responsibilities. One staff member said, "If something happens, we document and report it."

● The registered manager had recorded and reported safeguarding concerns, incidents and accidents when necessary.

Staffing and recruitment

● Staff had been recruited safely to ensure they were suitable to work with people who may be vulnerable. Required checks were in place before employment commenced including references and Disclosure and Barring Service checks [DBS].

● Enough staff were employed at the service to meet people's needs. During a recent COVID-19 outbreak, staff numbers had been increased to provide one to one support to people affected by the pandemic.

Using medicines safely

● Systems were in place to ensure people received their medicines safely and as prescribed.

● Staff had received appropriate medicines administration training and competency assessments.

● Medicines were stored safely, and administration records were completed fully. However, instructions for administering covert medicines lacked specific details on how to administer the medicines. Covert medicines are disguised in food or drink and given to a person without their knowledge. We addressed our findings with the registered manager during the inspection.

Learning lessons when things go wrong

● Accidents and incidents were recorded and analysed. These were discussed in handovers and staff meetings to ensure lessons were learned. Further analysis was undertaken by the providers quality team. The registered manager told us, "There are regular hand overs with staff, all incidents are discussed across the organisation."

Requires Improvement

# 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 good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Improvements were required to the culture within the service. The service did not always plan and ensure people were living their lives in a way that promoted choice, control and independence in line with the underpinning principles of Right Care, Right Support, Right Culture. These are a set of principles we expect health and social care providers to guarantee are in place for autistic people and people living with a learning disability.
- One person was not being referred to by their given name by staff and other people living at the service. There was no justifiable reason for this, and no consultation had taken place with the person or their family.
- Staff did not always speak to people in a way that promoted dignity and respect. There was a culture of paternalistic behaviour where staff were observed chastising people and referring to people as "a good boy". One staff member said, "Staff use a tone that is not right and will talk to people like a child."
- Although staff knew people well and how to manage their behaviours when anxious and distressed, we did not observe staff communicating with people as detailed within their care plans. For example, some people living at the service preferred to communicate using sign language, however we observed staff responding to them verbally.

Whilst we found no evidence that people had been harmed, people using the service were not always treated with respect and dignity whilst receiving care and treatment. This is a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The leadership, governance and culture at the service did not always support the delivery of high-quality care. The registered manager did not lead effectively and did not create a culture that supported people to live their lives with choice, control and independence.
- Systems and processes in place to monitor the quality of care people received were not always effective and did not always identify issues with care provision and the quality of care delivery. This meant people were possibly placed at risk of harm.
- Risk assessments did not always identify the risks posed and how staff should support people to manage and mitigate the risks.
- The registered manager had not understood they needed to report a recent COVID-19 outbreak to the Health Protection Team and other system partners as stated in the company COVID-19 contingency plan

and in line government and CQC guidance.
● Staff had been provided with specialist training in response to people's individualised health care needs. However, this training was not always put into practice to promote good outcomes for people.
● The registered manager completed a variety of checks and audits including medicines management, health and safety and competency assessments of staff performance. An overarching quality monitoring system was overseen by the provider. This system had not identified some of the issues we found at this inspection.

Whilst we found no evidence that people had been harmed, systems were either not in place or robust enough to demonstrate that there was adequate oversight of the quality of care at the home. This placed people at risk of harm. This was a breach of regulation 17 (Good 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 registered manager understood duty of candour and was open and honest when things went wrong. Relatives told us the service contacted them if incidents happened. One relative said, "They contact me if something has gone wrong."
● The registered manager had raised safeguarding alerts and reported incidents to CQC when necessary.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others
● Relatives told us they were involved with the delivery of care to their family members and were kept informed of any changes. One relative said, "I'm very satisfied with how [person] is being cared for. There is good communication, they have kept us up to date with COVID-19. They have managed everything really well."
● Relatives had completed a satisfaction survey in August 2020 about the quality of the care provision at the service. Responses had been mixed and relatives had provided suggestions for improvement. The registered manager told us they had used this survey to implement an action plan with staff and their inhouse multidisciplinary team to improve the service and had provided feedback to relatives.
● People living at the service were supported by staff to provide feedback about the service and the care they received.
● Staff told us they were able to raise concerns with the registered manager. One staff member said, "You can raise any concerns with the manager, they are lovely."
● Staff told us they attended daily hand overs there were regular team meetings where they could discuss concerns, share learning of make suggestions for improvement. Records showed and staff confirmed they received regular supervision.
● The service had their own in-house team to support people's health care needs including a speech and language therapist [SALT] and positive behaviour support [PBS] practitioner. The service also worked with learning disability and mental health professionals to support peoples care and wellbeing.

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 10 HSCA RA Regulations 2014 Dignity and respect<br><br>People using the service were not always treated with respect and dignity whilst receiving care and treatment. |