Premiere Care (Southern) Limited

The Willows Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The Willows Care Centre provides accommodation, personal and nursing care for up to 40 older people, people living with dementia or people with a mental health condition. The service is a large converted property. Accommodation is arranged over three floors and a lift is available to assist people to get to the upper floors. There were 37 people living at the service at the time of our inspection.

At the last inspection, the service was rated Good.

The inspection was prompted by a number of concerns raised by whistleblowers, people's relatives and local authority commissioning and safeguarding staff. The concerns included a lack of leadership, people not receiving care to meet their needs, poor medicines management, people's complaints not being acknowledged and acted on, reduced staffing levels, staff not having the skills to meet people's needs, poor working relationships between staff and poor or inaccurate records.

There was a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the care and has the legal responsibility for meeting the requirements of the law. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered persons did not have oversight of the service. They had not supported staff to provide a good level of care or held them accountable for their responsibilities. A care consultant's audit in October 2016 had identified a number of shortfalls in the service that we found at the inspection. Action had not been taken to improve the service following this audit.

People were not always treated in a kind and caring way and were not always treated with respect. For example, one person was given their medicine in some yoghurt while they were eating a savoury meal.

Some staff did not know the signs of possible abuse. Safeguarding risks had not been identified and referred to the Kent local authority safeguarding team for their consideration or investigation. Some staff had contacted the Kent local authority safeguarding team and CQC about concerns they had about the care people received.

Risks to people had not been consistently identified, assessed and reviewed. Action was not always taken to reduce risks. Detailed guidance was not available to staff about how to keep people safe.

Staff did not have the skills and guidance they required to keep people safe in an emergency. Following our inspection we informed the local Fire and Rescue Service about the risks we found.

Care had not been provided to keep people as healthy as possible. For example, care had not been planned

for one person following an injury and treatment at the local hospital. Nurses did not follow the provider's medicines procedures to protect people from the risk of unsafe medicines management, including the safe storage and administration of medicines.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Applications had been made to the supervisory body for a DoLS authorisation when people were restricted.

Staff did not follow the principles of the Mental Capacity Act 2005 (MCA). Assessments had not been completed of people's capacity to make specific decisions. People were not consistently supported to make day to day decisions.

People did not have enough to do during the day. Their interests and preferences had not been considered when staff planned activities. One person told us they were lonely in their bedroom and had nothing to do or listen to.

People told us they liked the food at the service and portions sizes had increased following their complaints. People were not always offered food to help keep them as healthy as possible. Meal times were not planned to make sure that people had regular meals spread throughout the day.

People were not protected by safe recruitment procedures. Disclosure and Barring Service (DBS) criminal records checks had not been completed for all staff before they began working unsupervised with people. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Potential risks to people from staff had not been assessed and action had not been taken to manage them.

People had to wait for the care they needed, for example, support to eat or have a wash. The registered manager had not made sure sufficient staff were deployed at all times to meet people's needs.

Staff had not completed training in key areas or to make sure they had the skills to provide effective care to everyone, such as how to support people with mental health needs. Some staff told us they did not feel supported. They did not meet regularly with the registered manager or team leader to discuss their role and practice. Concerns about staff practice had not been addressed with them.

Complaints made by people and their relatives made had not been recognised. They had not been resolved to people's satisfaction or used to improve the service.

People and their relatives, staff and other stakeholders such as GP's had not been asked for their feedback on the quality of the service to help the provider identify shortfalls and continually improve the service.

Staff did not maintain accurate records about the care people received. Information was not available to staff and health care professionals to help them identify any changes in people's needs. People's personal information was stored safely.

The registered manager had not notified CQC of significant events that had happened at the service. Services that provide health and social care to people are required to inform the CQC, of important events that happen in the service like a serious injury or safeguarding concerns. This is so we can check that appropriate action had been taken.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the back of the full version of the report. During and after the inspection, the provider took action to start to put things right and to improve the care and support for people. They engaged with the local authority and employed a consultant to help improve the service for people. Following our inspection they sent us an action plan detailing how they would address the concerns identified during the inspection. We will follow this up at the next inspection.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Not all staff knew how to recognise abuse. Concerns had not been referred to the Kent local authority safeguarding team for investigation.

Risks to people were not always assessed. Action had not been taken to support people to be as safe as possible. Staff did not know how to keep people safe in an emergency.

Medicines were not always managed safely.

There were not always enough staff to help people when they needed it. Staff had not been recruited safely or in line with the provider's procedure.

Is the service effective?

Inadequate

The service was not effective.

Care had not been planned to meet people's health care needs.

Staff did not always follow the principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

Staff had not had the training or support they needed to meet people's needs.

People told us they liked the food at the service but people were not offered food to meet their needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were not always kind and caring to people.

People were not treated with respect.

Staff did not know people's likes, dislikes, preferences and information about peoples' life history.

People were given privacy.

Is the service responsive?

Inadequate

The service was not responsive.

People and their relatives had not been involved in planning their care. Detailed guidance was not available to staff about how to meet each person's needs.

People did not have the opportunity to take part in activities they enjoyed.

People's complaints had not been investigated or resolved to their satisfaction.

Is the service well-led?

Inadequate

The service was not well-led.

Checks the provider and registered manager completed on the quality of the service were not effective. The checks had not found the shortfalls we identified.

Action had not been taken to regularly obtain the views of people, their relatives, staff and health professionals.

Records about the care people received were not consistently accurate and there was a risk that people would not receive consistent care.

The registered manager had not made sure staff knew about their responsibilities.

The registered manager had not shared important information with CQC, to help us understand what had happened at the service.

The Willows Care Centre

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 checked 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. This was a comprehensive inspection.

This inspection took place on 17 and 18 January 2017 and was unannounced. The inspection team consisted of two inspectors, a pharmacy inspector and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we inspected the service sooner than we had planned to look at concerns we had received. We looked at notifications received by the Care Quality Commission which a provider is required to send us by law. Notifications are information we receive from the service when significant events happen, like a death or a serious injury. We reviewed information we had received from people's relatives and whistleblowers.

We spoke to a clinical nurse specialist for older people, a lead safeguarding nurse, a case manager, continuing health care nurse assessor, local authority commissioners and safeguarding staff who had given the registered manager guidance about how to improve areas of the service.

During our inspection we spoke with seven people living at the service, four people's relatives and friends, an assistant dietician, the provider's nominated individual, the registered manager, and staff. We visited some people's bedrooms with their permission; we looked at care records and associated risk assessments for five people. We looked at management records including staff recruitment, training and support records, health and safety checks for the building, and staff meeting minutes. We observed the care and support people received.

Some people were unable to tell us about their experience of care at the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us

understand the experience of people who could not talk with us. We looked at medicines records and observed people receiving their medicines.

We last inspected The Willows Care Centre in October 2014 and rated the service Good overall.

Inadequate

Is the service safe?

Our findings

People told us they felt safe at the service. However, we found that people were not always safe at The Willows Care Centre.

One person had been 'slapped and punched' by another person. The registered manager did not know about the incident. Staff had not considered this incident to be a safeguarding concern. They had not reported their concerns to the registered manager or the Kent local authority safeguarding team as they should have done. The Care Quality Commission (CQC) had not been notified of this incident, as required by law.

The registered manager was aware of safeguarding procedures but had not always adhered to them. Some staff knew the signs of possible abuse, such as changes in people's behaviour or bruising, other staff did not. Eleven staff had not completed training on keeping people safe from abuse and harm, including half of the nurses. Some staff had whistle blown to the local authority safeguarding team or to the CQC when they had concerns about their colleagues' practice.

Risks of people being restrained unnecessarily had not been identified and managed. An incident report about one person's behaviour stated '[Person's name] was trying to kick, punch and bite me while [staff member's name] cleaned their bottom. I held their arm to stop them hitting me. When we were finished I let go and they punched me in the face'. Strategies to support the person had not been agreed to make sure that they were not restrained unnecessarily and any restraint was done in a safe and lawful way. Staff had not been trained to restrain people in a safe way and only as a last resort.

The registered persons had failed to effectively operate systems and processes to protect people from abuse or unnecessary restraint. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people had not been consistently identified, assessed and reviewed. Action had not always been taken to reduce risks and provide staff with guidance about how to keep people safe.

People were not consistently protected from the risks of losing weight. One person was prescribed high calorie drinks in September 2016 because they were at risk of losing weight. Staff did not know about this and the person was not receiving the drinks. The person had lost a significant amount of weight October 2016. Their weight loss had not been considered when assessing their risk of malnutrition and dehydration and the increased risk to them had not been identified. A health care professional told us they had instructed staff to refer the person to a dietician for advice and guidance in October 2016. Staff had not done this and the person lost more weight in November. Staff referred the person to the dietician at the end of December 2016.

People were not always moved safely. We observed one person being moved from a wheelchair into an armchair with a toilet sling. A toilet sling is usually used only to transfer people onto and off of the toilet as it

offers less support than a standard sling. The person was not well supported by the sling and appeared uncomfortable. We asked staff why they had used a toileting sling rather than a standard full body sling to move the person. They told us, "This is the sling I was told to use by the team leader. It's a full body sling". Another staff member described to us how a standard sling was used to support the person. Guidance had not been provided to staff about the equipment and techniques they should use to move people safely.

Risks to peoples' skin health, such as the development of pressure ulcers, had been assessed. However, the assessments were not consistent. One person's file contained two assessments completed on the same day. The scores on the assessments were different but the overall risk was the same. There was a risk that the severity of risks to people would not be identified. Guidance about the support people should be offered to keep their skin healthy was not easily available to staff because it was stored in the registered manager's office away from where people received their care. Staff relied on each other to know about how to manage risks to people.

People were not always provided with the pressure relieving equipment they were assessed as needing. People who are risk of developing sore skin need to have pressure relieving equipment, including cushions and mattresses in place. We observed that one person, who remained in bed all the time, was laying on a foam mattress. Their care plan stated they needed an airflow mattress. Staff told us the person's airflow mattress had been very stained and dirty and they were unable to clean it, so they had changed it. They had not taken action to obtain the type of mattress the person needed to manage the risk of them developing skin damage.

Guidance had not been provided to staff about the correct settings to make sure each airflow mattresses offered people the maximum benefit. Settings were not checked to make sure they were correct. Using a pressure relieving equipment that is too firm or soft may not give people the best protection from developing skin damage.

There had been occasions when people displayed behaviours that may challenge. These incidents were documented by staff. The registered manager told us they reviewed incident records to see what action should be taken to reduce the risk of them happening again. Staff told us they did not get close to one person 'unless they needed to' as the person may hit them. One incident form stated "I tried to have a general conversation with them. [Person's name] slapped me round the face and kicked me in the belly. They punched [staff members name] on the nose". The registered manager had not discussed with staff why they were so close to the person and what might have triggered the incident so the staff approach could be reviewed.

A fire evacuation plan was in place but staff were not clear about the action they needed to take to keep people safe. Less than half of the staff had completed fire safety training. Fire evacuation equipment was available but some staff did not know about it. Other staff told us they had not practiced using the equipment and were not confident to use it.

People's personal emergency evacuation plans (PEEPs) did not include guidance to staff about how to move people to keep them safe in an emergency. Staff told us they would 'get the people we can out'. Following our inspection we informed the local Fire and Rescue Service about the risks we found. Regular tests were carried out on extinguishers, emergency lighting and fire doors.

The registered persons had failed to assess and mitigate risks to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before our inspection we received concerns from whistleblowers about how medicines were managed at the service. We found people were not always protected from the risks of unsafe medicines management. The provider had a policy in place for the safe management of medicines; however staff had not read the policy and did not know the standards the provider required. The competence of nurses to manage medicines safely had not been checked.

Effective systems were not in place to order people's medicines; some people had not received their medicines because they were out of stock. These included medicines for the treatment of high blood pressure, depression and Alzheimer's disease. People had not received the medicines they needed to stay well.

A pharmacist had not been consulted about the best ways to support people to get the maximum benefit from their medicine. One person's tablet was crushed and given to them in a yogurt. Dairy products reduced the absorption of the medicine and there was a risk that it would not be effective. Advice had not been obtained from a pharmacist to check if medicines could be prescribed in a different form, such as a liquid medicine if people had problems swallowing tablets.

Medicines were not always administered in line with doctor's guidance. For example, one person's medicine was prescribed twice a day and the dose was to be spaced evenly, every 12 hours. The medicine had been administered at 08:00 and 17:00. There was a risk that the person would not get the full benefit of the medicine.

We looked at people's medicines administration records (MARs) and other records used to monitor the administration of medicines. Some people were prescribed variable doses of medicines for example, one or two pain relief tablets. The number of tablets people had taken had not been recorded and there was a risk that people may receive more than the maximum dose of their medicine.

Some people were prescribed medicines 'when required', such as pain relief or to help them relax when they were anxious. Guidance had not been provided to staff about the 'when required' medicines each person was prescribed, such as when it should be offered, how people might tell staff they needed it, or the minimum time needed between doses. There was a risk that people would not receive their medicines when they needed them or would be given their medicines when they were not needed.

Twenty people received their medicines without their knowledge disguised in food or drink, known as 'covert medicine administration'. Nurses administering medicines did not understand what covert medicine administration was. A nurse told us a person who received their medicine hidden in their food was not given their medicine covertly as it was not crushed. This was not correct as the medicine was being given covertly even though it was not crushed.

Nurses administered everyone's covert medicines in the same two yoghurts. Nurses told us the two half pots of yoghurt used at the lunchtime medicine round were left over from the breakfast medicines round. A separate spoon was used for each person, but the yoghurt might be cross contaminated with residue from crushed tablets. There was a risk that people would not receive the prescribed dose of their medicine or would receive a small amount of medicine they were not prescribed. People had not agreed and decisions had not been made in people's best interests to administer their medicines covertly.

The provider had a policy for the management of 'homely remedies' and a stock of pain relief was held at the service. Records had been kept of when people had been given homely remedies, however their GP had not been contacted to check that they were able to take the medicine with other medicines they were

prescribed.

Before our inspection we received concerns that people's pain relief patches were not being administered or came off because they were not applied correctly. Records of when and where patches had been applied were kept, however, checks were not completed to make sure the patches remained in place and there was a risk that nurses would not know if they had fallen off.

People's medicines were not always stored safely. Some medicines were stored in a medicines fridge. The maximum and minimum temperature of the fridge was taken daily and recorded. Records showed that the temperature had been too high on occasions. Action had not been taken to make sure medicines were always stored at the correct temperature and nurses did not know how to reset the thermometer. There was a risk that high temperatures would reduce the effectiveness of people's medicines.

The registered persons had failed to operate proper and safe medicines management processes in relation to the administration, storage and recording of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before our inspection we received concerns that staffing levels were reduced at times and people had to wait a long time to receive the care they needed. We found these concerns to be correct.

Nurses and care staff were not consistently deployed to the levels the registered manager told us were required to meet people's needs. Nurses told us when one nurse was on duty they were rushed and people had to wait a long time for their morning medicines. We observed that some people did not receive their medicine prescribed to be taken at 8am until 11:30am. One staff member told us, "Some days there are not enough staff. Sometimes there are only seven or eight. There should be a better system in place for back-up".

We observed some people had to wait to receive their care in the morning and were not supported to get up, washed and dressed and go downstairs for breakfast until 11:15am. Lunchtimes were a busy time at the service. Staff were not deployed to make sure that people did not have to wait for their meals or support.

Some people were supported to wash in the afternoon as staff did not have time to provide their care in the morning. Many people were living with dementia. Helping people living with dementia to continue with their usual routine helps them understand what time of the day it is and what they should be doing.

There were six health care assistant and two nurse vacancies at the time of our inspection. No registered mental health nurses were employed to lead the care of people with mental health needs. The registered manager told us that there was a high level of staff sickness absence which they were monitoring. Some of the vacant shifts were covered by agency staff. Other shifts were not covered. An agency nurse working at the service during our inspection told us they had worked two shifts in the service and did not know people well.

The registered persons had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's recruitment process had not been consistently followed. Checks required to make sure staff were honest, trustworthy and reliable had not been completed for all staff. References with information about staff's conduct in their last employment had been obtained but apparent risks had not been explored.

Disclosure and Barring Service (DBS) criminal records checks had not been completed for all staff before they began working unsupervised with people. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. One staff member had been working at the service for several months without a DBS check in place. They had declared at interview that they had convictions. The registered manager did not know what the convictions were for. We observed the staff member working unsupervised with people and supporting them in a rough way. We told the registered manager and provider what we had observed. The registered manager arranged for the staff member to be supervised until they had the opportunity to discuss the concerns with them. Some staff's DBS checks showed they had cautions or convictions, including serious convictions. Action had not been taken to assess and manage possible risks to people from these staff members.

Some staff had completed health questionnaires as part of the recruitment process, others had not. One staff member had stated they had a health condition at interview. The registered manager told us they did not believe the staff member had the condition and had not discussed it with them. Checks had not been made to make sure that reasonable adjustments could be made to support staff to properly perform their role.

The registered manager told us they had concerns about the practice of some staff. The concerns had not been investigated and appropriate measures had not been put in place to reduce any risks to people.

Checks on the identity of staff and the qualifications of nurses had been completed. Nurses' personal identification numbers were checked to make sure they were registered with the Nursing and Midwifery Council.

The registered persons had failed to operate effective recruitment procedures to make sure staff were of good character and had the experience necessary for the work they perform. The registered persons had failed to respond to concerns about a person's fitness after they were appointed to a role. The registered persons had failed to ensure staff were able to properly perform tasks intrinsic to their role, by reason of their health, after reasonable adjustments had been made. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Care had not been provided to keep people as healthy as possible. One person's relative told us they had arranged dental care for their relative as they had a sore mouth. The person had not been supported with their mouth care and had not had regular dental check-ups. This had resulted in them losing teeth and having extractions. Staff told us they did not support people to have regular dental check-ups. Another person's relative told us staff had acted quickly to have their relative's glasses repaired when they had broken.

Guidance was not available to staff about the support people needed to manage medical conditions such as epilepsy. One person's care plan stated 'If sitting next to the window or radiator can trigger a seizure'. Guidance was not provided to staff about the type of seizures the person had and the care and support they needed to manage a seizure. There was a risk that the person would not receive the care they needed to remain as healthy as possible.

Care had not been planned to support one person after they sustained a head injury which required treatment at the local hospital accident and emergency unit. Staff did not know when the person had returned from the hospital and what, if any, care they needed. Regular checks of the person had not been planned or completed. Staff did not know if there were any signs or symptoms that may indicate that the person required further treatment.

Care had not been planned to support people to manage their mental health needs. One person's care plan stated, 'Exhibiting aggressive behaviour occasionally due to psychotic mental state, but mainly settled'. Staff and the registered manager did not know about the person's mental health condition, signs of deterioration and how to support them. There was a risk the person would not receive the care and support they needed if they became unwell.

A Registered Mental Health Nurse was not employed by the service to plan, support and advise about people's mental health care to help them stay as well as possible. Staff told us they did not know how to respond to people when they showed behaviours that challenge. They had not received training and guidance about how to provide support people with their behaviours. There was a risk that people would not receive consistent care in ways they preferred to support them with their mental health needs on a day to day basis. Staff relied on the advice and guidance of the local mental health team for advice in a crisis.

The registered persons had failed to ensure people were safe and had the support they needed to manage their health needs. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 make 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 so that they can 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.

Two thirds of the staff had not completed training on the principles of MCA. In October 2016 the provider's care consultant had identified that staff were not complying with the principles of the MCA and people had not been involved in making decisions about their care. Action had not been taken to make sure that people were supported to make decisions in ways they preferred and to ensure that staff were working in line with the MCA.

People's ability to make particular decisions had not been assessed and staff had made decisions on their behalf. For example, some people had bedrails on their bed to reduce the risk of them falling out. Their ability to make the decision to use the bedrails had not been assessed and staff had made a decision in the person's best interests. People and their relatives had not been asked to be involved in making the decision.

Information was not provided in different ways to support people to make decisions. For example, a menu with pictures was displayed in the lounges. It was very small so there was a risk the some people would have difficulty seeing it.

Some people needed support to make decisions and tell staff what they wanted. Guidance had not been given to staff about how people would tell them what they wanted. Some staff supported people to make day to day decisions but other staff did not. For example, the staff member supporting one person at lunchtime did not ask them if they would like to sit at the dining table, which was very close to where they were sitting in an armchair. A different staff member encouraged another person to sit at the dining table as they usually preferred and supported them when they chose to sit in an armchair in the lounge. There was a risk that people would not be supported to make decisions in the way they preferred.

Several people were the subject of a DoLS authorisation and others were waiting to be assessed by their local authority. Applications had been made appropriately and people were supported to move freely about the building.

The registered persons had failed to assess and plan people's care in accordance with the Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's induction process for new staff, including working alongside established staff and being supported by a mentor was not being followed. We observed one new staff member who was not supervised or supported by other staff. They told us their induction was 'very vague' and they were 'very confused' about what they were expected to do. Staff's competence had not been assessed as part of their induction to check they were providing people's care to the standard required.

Staff did not have all the skills they needed to meet people's needs and protect them from harm. Staff had completed moving and handling training. Their ability to move people safely had not been assessed. We observed staff using a 'drag lift' to move a person in their armchair. Health and social care professionals told us they had also seen staff using this manoeuvre. This type of lift should not be sued as it poses a risk to the

person and to staff. We also observed people being moved in wheelchairs with their feet dragging along the floor. The registered manager did not know that staff were using unsafe practices which put people at risk.

The provider had recognised that staff had not received training in key topics such as fire safety. A plan was in place to train staff in basic skills and courses had been booked. Staff had not received training in topics specific to people's needs such as mental health, sensory impairments or communication. Nurses had not been supported to keep their clinical skills up to date, including revalidations required to maintain their registration to practice. Before our inspection we had received concerns about nurses' medication management practice. Assessments of nurses' practice had not been completed to make sure any shortfalls were identified and so nurses could be supported to improve their practice.

Staff had not met regularly with a manager or team leader on a one to one basis for supervision and coaching. They had not had the opportunity to discuss their practice and development needs. Records showed that some staff had received one supervision meeting in 2016. What had been discussed and agreed had not been recorded so actions could not be followed up at the next meeting to check they had been completed and were effective. Team leaders had not received training and support to develop their supervisor skills to make sure one to one meetings were completed in the way the provider expected.

Nurses had not received clinical supervision. The purpose of clinical supervision is to provide a safe and confidential environment for nursing staff to reflect on and discuss their work and personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice.

The registered persons had failed to appropriately support and train staff to be competent to fulfil their role. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before our inspection people's relatives had told us they were concerned about the size of the meals people were offered. They also raised their concerns with the provider who made sure portion sizes increased and people always had enough to eat. People confirmed that the size of the meals had increased to their satisfaction.

Some people told us they liked the food at the service, their comments included, "The food is good. There is enough of it", "Meals are good here" and "Staff get my breakfast when I want it. I like to have cornflakes in the morning".

People's relatives told us that meals were not always prepared to meet their relative's needs. We found this was correct. People's needs were recorded in their care plans but were not known by staff. For example, people who were not able to eat wheat were given wheat cereal for breakfast. People who were not able to tell staff about their needs had been given foods they should not eat. There was a risk that this had made them unwell.

Meals times were not planned around people's needs and preferences. The registered manager told us that they had stopped night staff supporting people with their breakfast as, "They weren't writing it down and day staff didn't know what people had eaten". Some people did not start eating their breakfast until 11:15am. Everyone was offered lunch at 12:30pm regardless of when they had eaten their breakfast and there was a risk they were not hungry.

People's food records showed that some people had missed meals as they were offered so close together.

For example, one person's records showed they had eaten their breakfast at 10:00am, their lunch at 12:00pm and had declined their dinner at 16:00pm. The person had not eaten between 12:00pm and 21:00pm when they had a slice of cake for supper. Action had not been taken to make sure that people were offered food regularly and at times they preferred.

An assistant dietician told us the number of people referred to the dietician service by the staff was higher than they expected. They said staff 'seem to fortify foods' with extra calories and people they had seen had put on weight. However, we found that people who were at risk of losing weight had not been regularly offered fortified foods and drinks.

The registered persons had failed to provide everyone with suitable food which was adequate to sustain health. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people were unable to eat or drink and received their nutrition through a feeding tube directly into the stomach called a percutaneous endoscopic gastrostomy (PEG). People received the support they needed to use the PEG and were offered a choice of staff to support them. When they chose a staff member who had not been trained to use the PEG, the staff member was supported by a nurse who made sure their care was safe.

Requires Improvement

Is the service caring?

Our findings

Some people and their relatives told us staff were kind and caring. One person told us "Staff are kind and gentle". Another person told us, "I am looked after". Other people's relatives told us staff were not kind and did not care for their relatives well. We found that some staff did not treat people with dignity and respect or provide them with reassurance when they were anxious.

Staff were not always caring. For example, we observed one staff member walking with a person pulling them by the wrist. The person was reluctant to walk and appeared anxious. The staff member continued to pull them by the wrist. We told the registered manager and provider what we had observed and a team leader supervised the staff member supporting people to move around the service to develop their practice.

Some staff walked through the lounges and did not engage with people. On occasions staff sat next to people but did not engage or talk with them. Other staff looked unsure of what to do and were milling around. Some staff engaged with people as they went about their tasks, stopping and chatting to them. People responded to staff and smiled. Some staff held people's hands and spoke to them quietly to reassure them. People responded positively to this and were relaxed and comfortable with the staff.

Staff did not always treat people with respect, including the language they used when they spoke about people. Staff described people who needed support with their meals as 'feeds' and people who needed support to change their position as 'turns'. One staff member told us they were allocated tasks each morning including "Lounges, turns and fluid run".

We observed one person taking their medicine at lunchtime. The nurse administering the medicine interrupted the person while they were eating a savoury meal to give them a spoonful of yoghurt containing their medicine. They then encouraged the person to continue to eat the savoury meal once they had swallowed the tablet and yoghurt.

People were not always supported to eat independently at mealtimes. We observed one person struggling to eat a jacket potato from a bowl with a spoon. The potato had not been cut up. We told a team leader that the person was struggling to eat the potato. They told us the person should not have been served the food before it was cut up. They cut the food up for the person. Other staff encouraged people to eat their meal without support by cutting it up for them and reminding them to eat. Some staff supporting people at meals times told people what the meal was and chatted to them as they ate. Other staff did not speak to people as they supported them.

Some people's spiritual needs were not met. One person was visited by their vicar, who told us the person's beliefs were very important to them. They told us that it was important the person's spiritual needs were met at the end of their life. The registered manager told us the person was receiving end of life care. The registered manager was not aware of the person's beliefs and had not planned their end of life care to make sure their spiritual needs were met. Other people's spiritual needs had not been considered and they were not supported to follow their beliefs if they wanted to. People relied on their friends and family to support

them with these needs.

Staff told us they did not know about people's likes, dislikes and had not been told about people's lives before they moved into the service. People and their relatives had been encouraged to complete 'This is me' documents. The 'This is me' was a form designed by the Alzheimer's Society to support people to share information about their cultural and family background; events, people and places from their lives; preferences and routines. These documents were not available to staff and had not been used to plan people's care. For example, some people's 'This is Me' stated that they liked music or liked to sing. Staff had not found out what music the people liked or offered them the opportunity to listen to it.

The registered persons had not taken action to make sure that people were treated with respect at all times and were supported to follow their beliefs. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's relatives told us they were able to visit whenever they wished and were informed of any changes in their relative's needs. One person's relative told us, "The staff let me know when things happen". They were able to continue to support their relative, with their relative's agreement and several people were supported at lunchtimes by their family. Another person's relative told us, "I am able to assist Mum. It helps to support her eating."

Staff told us one person had a preference about the gender of the carer who supported them. Staff made sure a carer of the person's preferred gender was always available to provide them with support.

People received their care in privacy. One person told us, "Staff get me dressed and are good at making sure I have private space". Staff knocked on bedroom doors before entering. One person's relatives told us, "Staff provide a private space for us to sit and have tea together". Confidential information about people was held securely.

People who needed support to air their views were supported by their families, care manager or an independent mental capacity advocate. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

Inadequate

Is the service responsive?

Our findings

Before moving into The Willows Care Centre people and their families had met with staff to complete an assessment of their care needs. A full assessment of their needs had not been completed and people had not been asked for important information including how they preferred their care to be provided.

Basic guidance about how to provide people's care was detailed in their care plans. Most of the care plans had been written by one staff member when they began working at the service. They told us they had not known people at the time and had not involved people, their relatives or experienced staff when planning people's care.

Staff told us peoples' care plans were not working documents and they did not refer to them for information about people's needs and preferences. Care plans were stored in the registered manager's office. Some staff told us they had not read people's care plans as they did not know they were able to. Staff relied on each other for information about how to provide people's care in their preferred way.

Detailed guidance was not available to support staff to provide consistent care to people in the way they preferred. For example, to ensure people were supported to move around with support when needed. One person's care plan said, 'Two staff to supervise. Unsteady on feet'. Guidance about how staff were to 'supervise' the person was not provided and staff used a wheelchair to move the person during our inspection.

One person's care plan stated they had 'visual and auditory hallucinations'. Guidance had not been provided to staff about how to support the person when they had hallucinations. We asked staff what impact the hallucinations had on the person. One staff member told us the person thought they were their son at times. We asked the staff member if they thought this was a hallucination or if the person may be confused because of their dementia. The staff member said the person was probably confused. Staff were not able to tell us what the person's hallucinations were like and how they supported and reassured them.

Some information about people was contradictory. One person's care plan stated they had poor eyesight and did not like to wear their glasses. The 'This is Me' completed by their family stated the person had good sight. There was a risk that people would not receive consistent care because some information about them was incorrect.

Reviews of people's care had been completed by staff. People and their relatives had not been invited to take part in reviewing and updating their care plans to make sure their views were included. The registered manager told us that in October 2016 they planned to introduce, 'celebrity client' to make sure people were involved in planning and reviewing their care plan and this information was available to all staff. They had not begun this process and alternative ways of involving people in planning and reviewing their care had not been considered.

The registered persons had failed to carry out with people an assessment of their needs and preferences

and had failed to provide person centred care that met people's needs with supporting care plans. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Many people were not offered support to do things during the day. One person told us they were lonely in their bedroom and had nothing to do or listen to. Two activities coordinators worked during the week. They spent some time doing activities with individuals. One of the activities coordinators spent most of their time supporting people to eat and drink in the dining room.

Staff told us one person liked to sing but became upset at times when they sang. They told us they discouraged the person from singing. Staff were not aware that the person had sung before they moved into the service. We asked staff if they thought singing upset the person or if singing might bring back memories and emotions. Staff told us they had not considered this and had not spoken to the person's family about it. They did not know the types of songs the person liked to sing and had not offered them opportunities to do this.

An activities plan was in place but was not followed consistently during our inspection as the activities coordinator was completing other tasks. People had not been involved in planning the activities which included 'ball time' and 'colouring'.

People told us they enjoyed having their finger nails painted and showed them to us. One person had their makeup applied during our inspection as an activity. They told us they liked wearing makeup and would like to wear it every day as they had in the past. Staff had not considered applying makeup was part of the person's morning routine and only offered them the opportunity to wear makeup occasionally.

Before our inspection several people's relatives told us about complaints they had made to the registered manager that had not been acted on and resolved. They told us about situations they had complained about, such as reduced staffing levels and poor care, that had continued to occur.

One person's relative had complained to the registered manager and staff on several occasions about the care their relative received, including them behind supported to eat food that did not met their needs and made them unwell. The person continued to be supported to eat these foods after the complaints were made, including during our inspection. There was a risk that this had made the person unwell and the side effects of this meant they had to remain in bed for a number of days.

A process was in place to receive and respond to complaints. The registered manager told us no complaints had been received. They had not recognised the concerns people's relatives had raised with them were complaints and had not taken action to resolve them and improve the service.

The registered persons had failed to receive, record, handle and respond to complaints by people's relatives. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager was working at the service and was supported by a 'lead nurse' and six team leaders. They did not have experience of working in a care home. They told us they did not know about the updated Health and Social Care regulations and their responsibilities as a registered person.

The registered manager did not know staff and people well. For example, they told us one person was receiving end of life care. We checked the person's records and spoke to staff and their care commissioner who confirmed they were not receiving end of life care.

Before our inspection visiting professionals, including a clinical nurse specialist for older people, a lead safeguarding nurse and safeguarding staff, told us they had offered the registered manager guidance and training opportunities to improve areas of the service. The registered manager told us they had not taken up their offers of support. For example, offers to provide training to staff about identifying and protecting people from abuse had not been taken up. Some staff did not know who to identify the risk of abuse and how to raise their concerns. Other staff had not reported risks to the registered manager or Kent Local authority safeguarding team so they could be investigated

The registered manager had asked us for training to complete their role. We recommended they refer to Skills for Care, a recognised provider of tools and support to adult social care organisations. The registered manager told us they had not referred to Skills for Care.

The registered persons had not taken up professional or expert advice to help them to identify and make improvements to the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff told us they did not feel supported by the registered manager. They told us the registered manager did not provide them with the support and guidance when they asked for it and was not accessible. Other staff told us they felt pressured to make decisions and complete tasks without support and guidance.

Some leadership roles had been delegated to the lead nurse and team leaders, including interviewing potential new staff and staff one to one meetings. Staff had not been supported to fulfil these roles and had not completed them in the way the provider required. The registered manager had not checked that the tasks were being completed to the required standard.

Staff had not been made responsible for other important tasks. For example, staff told us wipes people used

to clean their hands and mouths after meals were out of stock. The registered manager told us wipes were in stock. No one was responsible for making sure stocks of wipes were maintained in the dining room and lounges where people needed them. Staff supported people to wipe their hands with serviettes but these were not completely effective.

Information about the provider's philosophy of care was available in the service. It stated: 'We will ensure that you are treated as an individual with courtesy and respect, protect your privacy and dignity and enable you to gain and maintain as much independence as possible'. Staff did not know the provider's care philosophy. The registered manager had not supported staff to provide people's care in accordance with the principles. Staff told us the standards the registered manager required were 'work hard' and 'making sure paperwork is up to date'. Keeping records up to date was one of the main roles staff said they completed.

Some staff told us staff did not work together as a team to meet people's needs and staff worked in small groups or were 'on the outside'. Some staff told us they were isolated from the team by other staff members and the registered manager. One staff member told us there was 'tension' between staff at times. Another staff member told us they were 'Sick of staff gossiping and backstabbing about each other". The registered manager told us they knew staff did not work together as a team and had arranged a voluntary team building trip to the cinema. They had not considered recognised team building activities that involved the whole staff team.

Regular checks had not been completed on all areas of the service to make sure people received good quality care. A consultant audited the service in October 2016. They identified most of the shortfalls we found, including staff working without DBS checks and staff not complying with the Mental Capacity Act. Action had not been taken to address the shortfalls.

The provider told us they had relied on the registered manager telling them they had taken action to address the shortfalls at the service. They told us they had not checked that the registered manager had taken the action they said they had. The provider told us that they would complete more frequent and detailed checks of the service beginning immediately, after our inspection, to make sure improvements were made in all areas.

The provider had a survey in place to regularly ask people, their relatives and staff for their views about the quality of the service. However, they had not requested these surveys be completed for over a year. Residents and relatives meetings were held approximately every month. Some people's relatives told us they had raised concerns about meals at a meeting and improvements had been made. Other people's relatives told us they did not feel comfortable to raise concerns at the meetings and had not been offered alternative ways to raise their concerns. Systems were not in place to ask people and their relatives who did not attend the meetings for their views. Other stakeholders including district nurses, GP's and other professionals were not surveyed for their views.

The registered persons had failed to assess, monitor and improve the quality and safety of the service provided to people. They had failed to seek and act on feedback from relevant people, including people, their relatives, staff and visiting professionals, on the services provided to continually evaluate and improve the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before our inspection staff and people's relatives told us they were concerned about the accuracy of records in respect of people's care. We found that people's care records were not accurate and complete. For example, we looked at one person's daily records at 10:30am, these has been completed for the whole day

shift from 8am to 8pm and included 'hourly checks completed'. The staff member who had completed the record told us, "I know [person's name] will get this care during the day so I write it up now while I have time, otherwise I will be late finishing my shift".

Records of people's care did not contain information about what the person had done each day or the support staff had provided to them. Most people's daily records stated 'All personal care given with privacy and dignity maintained at all times'. Important Information about people was not recorded and available to staff and visiting professionals.

The provider and registered manager had failed to maintain an accurate, complete and contemporaneous record in respect of each person, including a record of the care provided to them and of decisions taken in relation to the care and treatment provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the CQC, of important events that happen in the service like a serious injury or deprivation of liberty safeguards authorisation. This is so we can check that appropriate action had been taken. The registered manager told us they did not know what significant events they needed to notify us of. They confirmed they had not notified us of significant events such as allegations of abuse or an incident investigated by the police.

The registered persons had failed to notify the Care Quality Commission of specific incidents that had occurred at the service. This was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

The provider had plans in place to refurbish the entire building including people's bedroom and communal areas. During and after the inspection, the provider took action to start to put things right and to improve the care and support for people. They engaged with the local authority and employed a consultant to help improve the service for people. Following our inspection they sent us an action plan detailing how they would address the concerns identified during the inspection. We will follow this up at the next inspection.

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 18 Registration Regulations 2009 Notifications of other incidents The registered persons had failed to notify the Care Quality Commission of specific incidents that had occurred at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered persons had failed to carry out with people an assessment of their needs and preferences and had failed to provide person centred care that met people's needs with supporting care plans.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered persons had not taken action to make sure that people were treated with respect at all times and were supported to follow their beliefs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered persons had failed to assess and plan people's care in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had failed to operate proper and safe medicines management processes in relation to the administration, storage and recording of medicines. The registered persons had failed to assess and mitigate risks to people. The registered persons had failed to ensure people were safe and had the support they needed to manage their health needs.

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 The registered persons had failed to effectively operate systems and processes to protect people from abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered persons had failed to provide everyone with suitable food which is adequate to sustain health.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered persons had failed to receive, record, handle and respond to complaints by people's relatives.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had failed to maintain

an accurate, complete and contemporaneous record in respect of each person, including a record of the care provided to them and of decisions taken in relation to the care and treatment provided.

The registered provider had failed to assess, monitor and improve the quality and safety of the service provided to people. They had failed to seek and act on feedback from relevant people, including people, their relatives, staff and visiting professionals, on the services provided to continually evaluate and improve the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered persons had failed to operate effective recruitment procedures to make sure staff were of good character and had the experience necessary for the work they perform. The registered persons had failed to respond to concerns about a person's fitness after they are appointed to a role. The registered persons had failed to ensure staff are able to properly perform tasks intrinsic to their role, by reason of their health, after reasonable adjustments have been made. The registered persons had failed to appropriately support and train staff to be competent to fulfil their role.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs.