Care Quality Commission

Hexon Limited

The Willows

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 10 June 2015 and was unannounced. This inspection incorporated a comprehensive inspection and a responsive inspection to follow up on requirements made at the last inspection.

We previously visited the service on 23 October 2014 and we found that the registered provider did not meet all of the regulations we assessed. We made a requirement in respect of two breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; this is now Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that staff did not use safe lifting techniques when assisting people to transfer and that staff did not have access to up to date guidance or published research evidence in respect of good practice in relation to care and treatment. In December 2014 the provider wrote to us to say what they would do to meet legal requirements. At this inspection we found that the breaches of regulation identified at the last inspection were now met.

Summary of findings

The Willows is registered to provide personal care and accommodation for up to 33 older people, some of whom may have a dementia related condition. There is a separate area of the home designated for people who are living with dementia. The home is located in Burton Fleming, a village that is close to Bridlington, a seaside town in the East Riding of Yorkshire. It is also close to the North Yorkshire boundary and both local authorities commission a service from the home. Most people have a single bedroom and some bedrooms have en-suite facilities. On the day of the inspection there were 25 people accommodated at the home.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager in post who had registered with the Care Quality Commission (CQC) on 7 December 2012. 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.

We found that the premises were not suitable to meet the needs of people who lived at the home. There was insufficient space for people accommodated on the first floor to live comfortably, to walk around the home freely and have access to outdoor space.

We saw that there were insufficient numbers of staff on duty to meet the needs of people who lived at the home and to enable staff to spend one to one time with people.

Two breaches of regulation were identified at this inspection. We found there were insufficient numbers of staff employed to ensure that the care and support needs of people who lived at the home could be met, and that the design of the premises was not suitable to meet the needs of people who lived at the home. You can see what action we told the provider to take at the back of the full version of the report.

There was a lack of quality auditing, and feedback from quality surveys was not collated or analysed to identify any improvement that needed to be made to ensure that people received care that was safe and promoted their well-being. We made a recommendation in respect of this shortfall.

People told us that they felt safe living at The Willows. Staff had completed training on safeguarding vulnerable adults from abuse and were able to describe to us the action they would take if they had concerns about someone's safety. They said that they were confident all staff would recognise and report any incidents or allegations of abuse. However, we saw that some products that could have caused harm to people were not stored safely and we made a recommendation in respect of this shortfall.

We observed good interactions between people who lived at the home and staff on the day of the inspection. People were supported to make their own decisions and when they were not able to do so, meetings were held to ensure that decisions were made in the person's best interests. If it was considered that people were being deprived of their liberty, the correct authorisations had been applied for.

People's nutritional needs had been assessed and people told us that they were satisfied with the meals provided at the home. People told us that they had ample choice and their special diets were catered for.

New staff had been employed following the home's recruitment and selection policies to ensure that only people considered suitable to work with vulnerable people had been employed. People who lived at the home and relatives told us that staff had the skills they needed to carry out their roles. Staff confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them.

Medicines were administered safely by staff and the arrangements for ordering, storage and recording were robust, although the auditing of controlled drugs (CDs) was infrequent.

People told us that the home was maintained in a clean and hygienic condition but we recommended that the prevention and control of infection was audited to ensure that this was continually monitored.

There were systems in place to seek feedback from people who lived at the home, relatives, health and social care professionals and staff, although these were not currently analysed and collated to identify improvements

Summary of findings

that needed to be made. People's comments and complaints were usually responded to appropriately although details were not always recorded in the complaints log.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service is not safe.

We found that there were insufficient numbers of staff employed to ensure that the needs of the people who lived at the home could be met.

The arrangements in place for the management of medicines were satisfactory and staff had received the appropriate training.

Staff had been recruited safely; they displayed a good understanding of the different types of abuse and were able to explain the action they would take if they became aware of an abusive situation.

We recommended that the prevention and control of infection policy needed to include the requirement for regular auditing and that more care needed to be taken with the storage of products that could cause harm.

Requires improvement

Is the service effective?
The service is not always effective.

We found that the design of the premises was not suitable for the people who lived at the home.

We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Records evidenced that staff completed induction and on-going training that equipped them with the skills they needed to carry out their role.

People had access to health care professionals when required and their nutritional needs were being met.

Requires improvement

Is the service caring?
The service is caring.

People who lived at the home and their relatives told us that staff were caring and we observed positive interactions between people who lived at the home and staff on the day of the inspection.

It was clear that people's individual needs were understood by staff.

We saw that people's privacy and dignity was respected by staff and that people were encouraged to be as independent as possible.

Good

Is the service responsive?
The service is responsive to people's needs.

People's care plans recorded information about their previous lifestyle, and their preferences and wishes for care were recorded.

Good

Summary of findings

People told us they were able to take part in their chosen activities although we observed these were minimal.

There was a complaints procedure in place that was understood by people who lived at the home and relatives.

Is the service well-led?

The home is not always well led.

There was a registered manager in post and they were undertaking additional training to improve their knowledge and skills.

There was a lack of auditing of the management systems in place and this did not promote the safety and well-being of people who lived and worked at the home. We made a recommendation about this in the report.

There were sufficient opportunities for people to express their views about the quality of the service provided but information had not always been collated and analysed to identify improvements that were needed to the service. We made a recommendation about this in the report.

Requires improvement

The Willows

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.

The inspection took place on 10 June 2015 and was unannounced.

The inspection team consisted of an 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. The expert-by-experience who assisted with this inspection had experience of supporting older people with dementia and other health problems associated with old age.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider, information we had received from the local authorities who commissioned a service from the home and information from health and social care professionals. The registered provider submitted a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

Prior to the inspection we contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they have had with the home. On the day of the inspection we spoke with four people who lived at the home, three members of staff, three visitors, health care professionals, the registered manager and the general manager.

On the day of the inspection we looked around communal areas of the home and some people's bedrooms (with their permission). We spent time observing the interactions between people, relatives and staff in the communal areas, including during mealtimes. We observed the care and support being delivered in the communal areas of the service and we spoke with people in private. We also spent time looking at records, which included the care records for three people who lived at the home, recruitment records for three members of staff and records relating to the management of the home.

Requires improvement

Is the service safe?

Our findings

At the last inspection on 23 October 2014 we found that the home was not always safe. We observed unsafe moving and handling techniques being used by care staff. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On this occasion we did not observe any unsafe moving and handling techniques being used by staff and saw they used appropriate equipment to assist with transfers. We also saw that care plans recorded specific information about the moving and handling equipment needed for people.

On the day of the inspection we spoke in detail with four people who lived at the home and chatted to others. We asked them if they felt safe and they all told us that they did. One person told us, “Yes because there are people about, and building is safe" and another said, "Yes because there's people surrounding me and they are friends." The visitors we spoke with supported this view. One visitor told us, “Yes, we feel the staff care, quite satisfied she is safe when I leave".

We asked people who lived at the home if there were sufficient numbers of staff around to meet their needs. We received differing views. One person told us, "For the amount of people yes, plenty of people around" but another person said, “No because at busy times staff are running about." Relatives also had differing views. One relative told us, "Yes most of the time, occasionally busy upstairs and a bit thin on the ground but this doesn't affect (my relative).” Another visitor described how they sometimes had difficulty locating a member of staff. They said, “Sometimes there is no member of staff visible. Yesterday I saw a man in his vest and underpants walk into the lounge.” They described how they had tried to resolve the situation in the absence of a staff presence. On the day of the inspection we saw two care staff assist someone to the toilet. This left the lounge unattended. We observed one person, who was very unsteady, start to walk across the room and a visitor tried to help them back to their chair. We felt there was a risk the person could fall and we intervened to ensure the safety of the person concerned.

We checked staff rotas and these recorded that there were four people on duty on most days, plus the registered manager from 8.00 – 4.00 pm from Monday to Friday. There were three staff on duty each night. On the day of the inspection we saw that there were two staff on duty on the ground floor (including a senior care worker) and two care staff on duty on the first floor, plus the registered manager from 8.00 am until 4.00 pm. Following the last inspection we had been told that there would be an additional member of staff on duty during the day from 8.00 am until 4.00 pm. However, there was no-one covering this shift on the day of the inspection. The general manager told us that this shift was usually covered but staff told us that this shift was rarely covered. A health care professional who we spoke with told us that they had always seen two staff working on the first floor where people living with dementia were accommodated. However, they said that they sometimes struggled to find staff to assist them on the ground floor.

Staff described numerous occasions when there had been insufficient numbers of staff on duty. They said that the registered manager has asked the head office if they could have additional members of staff, but they had been told that there were sufficient staff for the numbers of people living at the home. However, staff said that several people who lived at the home required the assistance of two staff for transfers. They told us that the senior member of staff who administered medication each day had to carry out this task on both floors of the home. This meant that the task took a considerable length of time to complete and that the person completing the medication round was not able to assist their colleagues during this period. Staff felt that this had not been taken into consideration when staffing levels had been determined.

The first floor lounge accommodated twelve people; this was the area of the home designated for people living with dementia. We saw that people were encouraged to sit in chairs and not walk around. We felt this was because there were insufficient numbers of staff to observe that people were safe if they chose to walk around the home whilst also undertaking activities and providing assistance with personal care.

Staff told us that, when they were short staffed, they were sometimes sent a member of staff from another home in the organisation. However, they said that this did not

Is the service safe?

always help, as they had to spend a lot of time explaining people's needs to them. There was a member of staff from another home within the organisation on duty on the day of this inspection.

Ancillary staff were also employed; there was a cook on duty every day and a domestic assistant on duty on six days a week. This meant that care staff had to prepare the tea each day and do basic domestic work on a Wednesday, which meant they had less time to spend with people who lived at the home. In addition to this, there was no activities coordinator so staff had to try to find time to undertake activities at some stage during the day, and no laundry assistant so care staff had to carry out laundry duties. Carrying out a variety of roles meant that staff had limited time to support people who lived at the home, and also posed an infection control risk.

Overall, we saw that there were insufficient numbers of staff on duty during the day and night to ensure that people who lived at the home received the care and support they needed.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they kept people safe by following safe moving and handling techniques and using the correct equipment, by making sure that doors were secure and making sure people had a safe and clean environment. However, we saw that the bathroom on the first floor had an unlocked cupboard with a large container of bactericide handwash inside. The bathroom cabinet was open and it contained shaving foam and disposable razors. We saw Steredent in an unlocked cabinet in a toilet on the first floor and in a person's bedroom. The registered manager told us that staff were told regularly to ensure that these products were stored in a locked facility, and that she would re-iterate this to all staff.

We recommend any products that could pose a risk of harm to people who live at the home are stored securely.

There were safeguarding policies and procedures in place and the manager submitted alerts to the local authority as required. We spoke with the local authority safeguarding adult's team and they confirmed that they had investigated some concerns that had been raised with them. They had made recommendations following these investigations and on the day of the inspection we were told about how some of these had been actioned. This evidenced that recommendations made as a result of safeguarding investigations had been listened to by the registered manager and shared with the staff team to reduce the risk of similar incidents reoccurring.

Training records evidenced that staff had undertaken training on safeguarding adults from abuse and staff who we spoke with confirmed this. They were able to describe different types of abuse, and were able to tell us what action they would take if they observed an incident of abuse or became aware of an allegation. Staff told us they felt all of their colleagues would recognise inappropriate practice and report it to a senior member of staff. One member of staff told us, "I'd make sure person was safe and report it straightaway." Staff who we spoke with also understood the principles of whistle blowing and we saw that the whistle blowing policy was discussed with staff during their induction training.

Staff told us that they had been through a thorough recruitment process. We checked the recruitment records for three members of staff and saw that the application form recorded the names of two employment referees, the applicant's employment history and a declaration that they did not have a criminal conviction. Prior to the person commencing work at the home, checks had been undertaken to ensure that they were suitable to work as a care worker, such as references, a Disclosure and Barring Service (DBS) first check and a DBS check. Documents to confirm a person's identity had been retained. These measures ensured that people who used the service were not exposed to staff who were barred from working with vulnerable adults.

We saw that a thorough interview had taken place that was recorded on an interview checklist, and that the applicant's responses were 'scored' to measure their suitability for the post. We noted that one person's induction records identified that they had poor written English and the registered manager told us that this would be addressed. Staff received a copy of their job description so they were clear about what their role entailed.

There were risk assessments in place for any identified risks and some of these included a scoring system to show the level of risk. We saw that everyone had a risk assessment in place on nutritional needs, pressure area care, the risk of falls, moving and handling and the provision of window

opening restrictors. In addition to this, people had individual risk assessments in place for areas such as the use of a wheelchair, use of the bath and / or mobility hoist, diabetes, bathing and use of the passenger lift. Risk assessments were reviewed by staff each month which meant that staff had up to date information to follow.

We saw that there were policies and procedures in place on the administration of medication.

There were two medication trolleys, one stored on the ground floor and one stored on the first floor. These were fastened to the wall within a locked cupboard. Medication was supplied in blister packs that were colour coded to identify the time of day they needed to be administered; the same colour coding was used to identify administration times on medication administration record (MAR) charts. This reduced the risk of errors occurring. One person was having respite care at the home and had brought their medication from home. We saw that this was stored in a plastic carrier bag and it was agreed that a more suitable storage container would improve the security of the medication.

All staff that administered medication at the home had undertaken appropriate training. The registered manager told us that she occasionally carried out the morning medication round with staff to check their competence, but these checks were not recorded. She agreed that these checks would be recorded in future to evidence that staff remained competent to carry out this role.

We observed the administration of medication and saw that this was carried out safely. The senior staff member did not sign MAR charts until they had seen people take their medication, people were provided with a drink of water so that they could swallow their medication and the medication trolley was locked when not in use.

There was a suitable cabinet in place for the storage of controlled drugs (CDs) and a CD record book. Controlled drugs are prescription medicines that are controlled under the Misuse of Drugs legislation. We checked a sample of entries in the CD book and the corresponding medication and saw that these balanced. Two staff had signed each entry in the CD book. However, we noted that there was evidence that the CD book and CDs had not been audited since September 2014. In addition to this, there was no audit of the overall medication system. This meant that there was a lack of monitoring to ensure that people were receiving the right medication at the right time. However, people who lived at the home told us that they received their medication on time and that they were aware of what their medication had been prescribed for.

We checked MAR charts and saw that, on occasions, two staff had not signed to confirm that hand written entries made on the MAR charts were accurate. When two staff check and sign hand written entries, this reduces the risk of errors occurring. There was a sheet included with each MAR chart that recorded the person's date of birth, the name of their GP and details of any known allergies. We saw that codes had been used appropriately when medicines had not been administered and the rear of the MAR chart recorded the reason why 'as and when required' medication had not been administered. There was an audit trail that ensured the medication prescribed by the person's GP was the same as the medication provided by the pharmacy.

The temperature of the medication fridge was taken daily to ensure medicines that required storage at a low temperature were held safely, and the temperatures of storage rooms were also taken. We noted that the upstairs medication cupboard was also used to store foodstuffs, although this did not impact on the safe storage of medication.

We noted there was an effective stock control system in place and the deputy manager told us that the date was written on liquid medication to record when it was opened and the date it expired. This was to ensure the medication was not used for longer than stated on the packaging. However, on the day of the inspection we saw that a small number of bottles / packages had not been signed by staff. We checked the records for medicines returned to the pharmacy and saw that these were satisfactory; a specific returns book was being used that recorded details of the medication to be returned.

There were checks in place to ensure that the premises were maintained in a safe condition to protect the well-being and safety of people who lived and worked at the home. There was a fire risk assessment in place, a current gas safety certificate in place, portable appliances had been tested and bath seats and hoists had been serviced. The fire alarm system had also been serviced in December 2014. The home's handyman carried out weekly or monthly checks on call bells, window opening restrictors, bed rails, water temperatures, the fire alarm

Is the service safe?

system, door closers and emergency lighting. However, we saw that there were long gaps when weekly fire tests had not been carried out. The registered manager assured us that these had been carried out but not recorded, and that they would ensure they were recorded each week in future.

We asked people living at the home if they felt the home was clean and hygienic. They all said they did. One person said, "Yes, it is done every day and my room is clean." The visitors who we spoke with also told us that they thought the premises were clean and hygienic. We saw that communal areas of the home were maintained in a clean and hygienic condition. However, we also noted that one person's bedroom had a dirty bathroom floor with used toilet paper in a plastic washing up bowl on the floor. This was rectified when we pointed it out to staff. The staff toilet was

being used to store mattress protectors and a wooden headboard, which left very restricted space around the toilet and wash basin, and made it difficult to keep the room clean and hygienic.

There were a variety of cleaning schedules in use that evidenced all areas of the home were cleaned on a regular basis, including monthly deep cleans. Domestic staff also carried out hygiene checks on mattresses, shower heads and pressure mats, and we saw that these cleaning / maintenance checks were recorded.

Following our last visit to the home when we shared some advice about the suitability of the laundry room, efforts had been made to create a 'dirty' and a 'clean' flow. Improvements had also been made to ensure the room could be cleaned more easily. However, we noted that the central heating boiler remained in the laundry room and the outer casing was rusty, making it difficult to keep clean. The registered manager told us that they would raise this with the registered provider and ask for a cover to be made for the boiler.

There had been a suspected outbreak of the Norwark virus following a person's discharge from hospital. There were records to evidence that all precautions were put in place and appropriate areas of of the home and equipment were steam cleaned.

There was no annual statement on the prevention and control of infection and no audit had been carried out. This would have evidenced that the registered persons were checking that the infection control policy in place at the home was being adhered to, and that the procedures in place were protecting people from the risk of harm.

We recommend that the policies and procedures in place on the prevention and control of infection include the requirement for regular auditing to be carried out by a nominated person.

There was a crisis (contingency) plan in place that included advice for staff on how to deal with emergency situations. There were lists of all staff who worked at the home, each person who lived at the home and their mobility needs, and other emergency numbers. In addition to this, there was a general evacuation plan in place for people who lived at the home. We discussed with the registered manager that it would be advisable to develop personal emergency evacuation plans (PEEPs) for each person who lived at the home to identify their particular needs for evacuation, such any equipment that would need to be used and how many staff would be needed to assist the person to leave the premises.

Any accidents or incidents had been recorded and we noted that a monthly analysis was being carried out by the registered manager to monitor whether any patterns were emerging and if any additional action needed to be taken. There was evidence that medical attention had been sought as needed.

Requires improvement

Is the service effective?

Our findings

At the last inspection on 23 October 2014 we found that the service was not always effective. We did not see any evidence that care for people living with dementia was based on published research or guidance. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 (3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that some signage had been introduced; laminated pictures had been placed on people's bedrooms doors that represented a previous occupation or an interest. This helped people to identify their bedroom. There was also signage to help people identify toilets and bathrooms. We asked people if they could find their way around the home easily and they told us they could. Relatives also told us that they thought signage for people was adequate. The minutes of the staff meeting held in April 2015 recorded that work was planned to paints doors different colours to aid identification for people who lived at the home. They also recorded that rummage boxes were going to be introduced in an effort to occupy people who were living with dementia, although we did not see any being used on the day of the inspection.

We saw that every member of staff had either completed training on dementia awareness or were currently undertaken this training. In addition to this, some staff had attended training on mental health conditions and on conflict resolution. This helped staff to understand the most appropriate ways of working with people who were living with dementia. The registered manager told us that 15 people at the home had been diagnosed with a dementia related condition so it was essential that staff had received appropriate training.

Each care plan included information from the National Institute for Health and Care Excellence (NICE) on dementia care; this was intended to be a reminder for staff about good practice guidance on supporting people who were living with dementia.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected.

None of the staff who we spoke with had completed training on MCA / DoLS and the training matrix did not include any details about this training. However, the general manager told us that the topics of MCA and DoLS were included in the home's safeguarding adults training. Discussion with the registered manager evidenced that they had a clear understanding of the principles of the MCA and DoLS, and we saw that if it was considered that people were being deprived of their liberty, the correct authorisations had been applied for.

Assessments had been carried out to record a person's capacity to make decisions, although we saw that the two-stage mental capacity test in one person's care plan had not been completed. We did not see any evidence of best interest meetings or decisions in the care plans we checked, but the registered manager and staff were able to explain when best interest decisions needed to be made. Best interest meetings are held when people do not have capacity to make important decisions for themselves; health and social care professionals and other people who are involved in the person's care meet to make a decision on the person's behalf.

Visitors told us that they had some involvement in making decisions on behalf of or with their relatives. One person told us they had regular meetings with the registered manager and another person told us they had power of attorney for their relative. This is when people have the legal right to make some decisions on behalf of another person.

Staff told us that they encouraged people to make choices, such as where to eat their meals, whether to sit outside and whether they wanted to stay in their bedroom. One staff member told us, "We encourage them to do what they can and maintain as much independence as possible - it is their home and their choice." People told us that they were consulted about their care; one person said, "They'll ask" although another person said, "They just get on with it." Staff told us they gave people as much control about their care and support as they could.

We observed that the first floor lounge was very small and noted that there were not enough lounge chairs to

Requires improvement

Is the service effective?

accommodate the twelve people who were living on the first floor, the area designated for people living with dementia. At the time of the inspection two people were being cared for in bed, but if everyone had chosen to sit in the lounge, there would not have been enough chairs to accommodate them. There was a small dining room but it only included two tables and five dining chairs. Again, this meant that everyone could not sit at a dining table to eat their lunch if that was their preferred choice. As a result, everyone ate in their bedroom or at a small table placed in front of their lounge chair, which resulted in space being very restricted. We were told by care staff that the people living on the first floor were not assisted downstairs so that they could spend time in the garden, which meant they did not have access to fresh air or activities that could take place outdoors, such as gardening. However, the general manager told us that people were not segregated and that people who were living with dementia could spend time in any of the lounge areas, upstairs or downstairs. On the day of the inspection we observed that people who were accommodated in the upstairs lounge remained there throughout the day. We asked staff if they thought the premises were suitable for the people who lived at the home. One member of staff told us, "The chairs (in the first floor lounge) are horrible and hard, and there is no room for soft recliners." On the day of the inspection we observed this to be the case.

There was a treatment room for visiting healthcare professionals to use. However, we noted that some items were stored on the floor as there were no shelves provided. In addition to this, there was no chair in the room so people could not sit down to receive treatment. This did not provide suitable facilities for people to meet with health care professionals in comfort.

This was a breach of Regulation 15 (1)(c) of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014.

Although we did not find a breach at the last inspection, we were concerned that induction training for staff was not robust. At this inspection staff confirmed to us that they had completed induction training, and that they had 'shadowed' experienced staff prior to working on the rota unsupervised. In the records for a new member of staff we saw evidence that they had commenced the Skills for Care common induction standards; Skills for Care is a nationally recognised training resource. Topics covered included fire safety, infection control, person centred care, safeguarding vulnerable adults from abuse, dealing with accidents, daily routines, health and safety and whistle blowing.

The registered manager told us that they considered mandatory training to include moving / handling and use of a hoist, infection control, health and safety, safeguarding vulnerable adults from abuse, fire safety, food hygiene, the control of substances hazardous to health (COSHH), nutrition and dementia. Some of this training needed to be completed annually and some every two years. The training records we saw evidenced that all staff had completed training on dementia awareness, infection control and moving and handling. The majority of staff had completed training in fire safety, first aid, safeguarding adults from abuse and health and safety. In addition to this, staff who had responsibility for the administration of medication had attended appropriate training.

Other courses available to staff included diabetes, the risk of falls, catheter care, equality and diversity, end of life care, healthy eating, stroke awareness, dysphagia and mental health. Records evidenced that most staff had completed training on equality and diversity and health eating.

The registered manager told us that staff were currently undertaking training on end of life care and medication. Staff told us that they took part in numerous training courses. One member of staff said, "I've recently done medication, safeguarding, moving and handling and fire training – we do loads." We also noted that most staff had completed a National Vocational Qualification (NVQ) or equivalent at either Level 2 or 3, and that the registered manager was undertaking this award at Level 5.

We saw that staff had attended appraisal meetings with a manager when they had the opportunity to discuss their training needs. Staff also attended supervision meetings, although we noted that these were more like one to one training sessions than supervision. This meant that staff had an opportunity to talk about their own support and training needs.

We saw there were systems in place to ensure that staff were aware of people's up to date care needs. A handover sheet was being used to record information each day and night and handover meetings took place at the beginning of each day and night shift. One member of staff told us that each person who lived at the home was listed on the

Requires improvement

Is the service effective?

handover sheet and this reminded them to share updates about people's individual care needs. The information shared at handover meetings ensured that all staff were clear about people's needs.

People had been provided with a personalised care plan from their GP surgery; this included details of their medical condition and the medication prescribed. People who lived at the home told us that they had good access to GP's, dentists and other health care professionals. One person told us, "They would get the doctor – I have seen him once." Staff told us that they would tell the senior care worker or manager if they felt someone needed to see their GP, and they would request a visit. Visitors told us that they were kept informed of any changes to their relative's health and well-being. One person told us, "Once (my relative) had a chest infection. It had not cleared up by antibiotics so I asked again for a doctor and one was there that afternoon." Health care professionals told us that staff asked for advice appropriately and then followed that advice.

There was a record of any contact people had with health care professionals; this included the date, the reason for the contact and the outcome. We saw records of appointments and contacts with GP's, district nurses and chiropodists, and we saw that one person with a diagnosis of dementia had attended a dementia monitoring clinic for a review meeting. We saw advice received from health care professionals had been incorporated into care plans. For example, there was information in one person's care plan that had been received from the dietician. Details of hospital appointments and the outcome of tests / examinations were also retained with people's care records. This meant that staff had easy access to information about people's health care needs.

People had patient passports in place; these are documents that people can take to hospital appointments and admissions with them when they are unable to verbally communicate their needs to hospital staff. They include details of the person's physical and emotional health care needs. This meant that hospital staff would have access to information about the person's individual needs.

We observed the lunchtime experience and saw that the meal looked appetising and hot. Staff who we spoke with had a good understanding of people's special dietary requirements, such as people with diabetes and people who needed their drinks to be thickened. They told us that the cook knew everyone's dietary needs.

There was a menu on display but we noted that it did not include pictures or symbols to assist people living with dementia to understand the meals on offer. The registered manager told us that care staff and the cook explained meals to people rather than showing them the menu. We did not see a choice of main meal being offered to people but staff told us that people were asked each morning what they would like for lunch. We did see that a choice of puddings was offered. People told us they liked the meal provided at the home. One person said, "Food is good – I can always ask for more, and I can ask for things like sprouts" and another said, "The food is excellent. I like ham sandwiches for tea." People also told us that their special diets were catered for. One person said, "I have to have special food. The cook comes and tells me what I can have and asks what I would like."

We saw a member of staff assisting someone to eat their meal; they chatted to the person and gave them plenty of time to eat their meal.

We saw care plans included a nutritional assessment that recorded the person's special dietary needs and risk assessments in respect of eating and drinking. When nutrition had been identified as an area of concern, charts were used to monitor food and fluid intake. We noted that accurate records were kept of fluid intake and that people were also weighed as part of nutritional screening. In addition to this, care plans included guidance about the importance of hydration. This served as a regular reminder for staff about the need to encourage people to drink regularly and in sufficient amounts.

The home had achieved a rating of 3 following a food hygiene inspection; this is an average score. We noted that this rating was not displayed as required. The registered manager told us that this rating was partly based on the fact that freezers storing foodstuffs were located in an outside shed. There were currently no plans for these to be located elsewhere.

Good

Is the service caring?

Our findings

We observed that relationships between people who lived at the home and staff were positive. People used their first names which created a friendly, informal atmosphere. People who lived at the home told us they felt staff cared about them. One person said, "You can talk to them, I think they do talk to me" and another said "Yes, one or two more than others - they ask how I am doing every day." The relatives and friends who we spoke with on the day of the inspection told us that staff really cared about people. One relative said, "Yes, (there is) interaction between staff and residents; staff take an interest in (my relative)" and another told us, "The whole attitude is good which shows (staff are) caring and understanding."

Staff told us that they felt they were a good team of staff and that everyone really cared about the people who they supported. One member of staff said, "Absolutely, without a shadow of a doubt."

We asked staff how they got to know about peoples individualised needs. They responded, "Yes we do, we sit and chat to residents" and "On admission we sit and talk to them and ask them their like and dislikes." A relative told us that staff maintained people's dignity and provided individualised care. We saw that care plans included information about each person's dependency levels; this included what they could do independently and what they needed assistance with.

People told us that staff communicated with them and shared information with them in a way they understood. One person said, "They talk to me and I talk to them" and another person said, "It depends how busy they are. They will talk to me when they have time."

A senior member of staff had been appointed as 'dignity champion'. The role of a champion is to take a special interest in a topic and gather information that would help them promote good practice amongst the staff team.

Each care plan included a laminated sheet that recorded information about promoting dignity; these were intended to remind staff about the importance of treating people with dignity and respect. The four people who we spoke with on the day of the inspection told us that they were treated with dignity and respect at all times. One person said, "I get a bath twice a week and they look after me" and another person told us, "Yes they do, they knock on my door.". Staff explained to us how they respected people's dignity. One member of staff told us, "We shut doors always, wait outside the toilet, cover with towels, knock on doors." Another member of staff said, "We place towels over their body to protect their modesty." One person told us that there were sometimes two male care workers on duty overnight, but there would always be a female care worker as well. This meant that people would be able to be assisted by a male or a female care worker if this was their preference.

The registered manager told us in the action plan they submitted following the inspection in October 2014 that they had arranged training for staff on privacy and dignity. The PIR submitted by the registered manager prior to the inspection recorded that this training had been completed by staff. We noted that this topic was not listed on the training matrix although we did see evidence of this training recorded in some staff's individual training records. We also saw that there was a risk assessment for each person in respect of privacy and dignity, although these were not personalised. The registered manager told us that they would address this to ensure there was personalised information about each person's privacy and dignity needs.

Most people had a single bedroom and this enabled them to spend time on their own if they wished to do so. Staff told us that they asked people what they required assistance with and what they could manage themselves, to promote their independence.

Staff told us that, because they knew people well, they were able to recognise changes in their behaviour that indicated they were unwell, or were unhappy, even when they were not able to verbalise this. They were able to give us some specific examples.

A health care professional told us that they had no concerns about the care of people who lived at the home. They said that staff asked for advice appropriately and then followed that advice. They said, "Staff are very good and work well with us." When there had been a change in a person's care needs, we saw that the appropriate people had been informed. This included their family and friends, and any health or social care professionals involved in the person's care. This ensured that all of the relevant people were kept up to date about the person's general health and well-being.

Good

Is the service responsive?

Our findings

Care plans recorded people's hobbies and interests and a statement that said, "I would like staff to find out what my interests and hobbies are so individual activities can be tailored to my needs."

On the day of the inspection some people were sitting outside as it was a sunny day and we noted that staff ensured they were wearing hats to protect them from the sun. We saw that staff did make efforts to chat to people whenever they had the time, but we did not see any activities taking place apart from a member of staff giving someone a manicure. However, people who lived at the home told us there were activities they could take part in. Comments included, "A company comes in and does exercises with us and some other entertainers", "They are waiting for the weather to improve and they are taking us out", "We have entertainers that come in" and "If there is something on I will go and do it – depends how busy they are." A relative also told us they were satisfied with the activities on offer at the home. They said, "Yes, (my relative) is in the communal area all day – listens to music and watches entertainment when it is on." Staff were able to explain to us about a variety of activities that took place, including quizzes and ball games. They said that someone visited the home each week to carry out some kind of entertainment.

The registered manager acknowledged that activities were not recorded in individual care plans but in a communal record. They told us that they intended that this information would be transferred to care plans.

There was a TV at one end of the ground floor lounge and the radio playing at the other end of the lounge and we felt that this did not provide a suitable environment for people to enjoy either the TV programmes or the music. There was no list on display to inform people of any activities that they could take part in and we discussed with the registered manager how this would be beneficial.

We saw that staff supported people to keep regular contact with relatives and friends. Staff told us, "Relatives are free to visit anytime" and "We encourage people to visit." Relatives and friends told us that they were able to visit the home at any time of the day.

Although people who we spoke with said they were not aware of their care plans, we saw staff entering information into care plans in the communal areas of the home. We saw in care plans that people's needs had been assessed when they were first admitted to the home. Assessments had been undertaken on moving and handling, personal safety, personal care, communication, social activities, resting / sleeping, tissue viability, eating / drinking, mental capacity and promoting privacy and dignity. This information had been used to develop care plans on each of the topics assessed. When an area of risk had been identified, risk assessments had been carried out to record the risk and how it could be minimised. We saw risk assessments in respect of diabetes, nutrition, the risk of falls, use of the hoist, not conforming to medication, bathing and use of a wheelchair.

There were a small number of discrepancies in care plans. For example, one person's dependency assessment recorded that they were 'mildly confused' yet the care plan recorded the person had dementia. The health care professionals visit record evidenced that a dietician had been asked to visit but there was no other information in the care plan to indicate why the visit was needed. Discrepancies in care planning documentation were highlighted during a recent safeguarding investigation carried out by the local authority. We saw that most care plans were up to date and did not include contradictory information; however, this was an area that still required improvement to evidence consistent practice.

Relatives told us that they had discussed their relative's needs with staff when they were admitted to the home to help staff understand how to support them. One person said, "Yes, the whole family was involved" and another said, "Always discussed what her needs are – they are approachable." There was information in people's records about care plan reviews that had been organised by the local authority who commissioned the service from the home. People and their relatives or representatives had been involved in these reviews.

We saw that care plans included information about people's individual ways of communicating. The care plan for one person who was living with dementia recorded, "Clear speech is needed as (the person) will try to answer simply to basic questions with 'Umm' or 'Yes'. Always wait for a reply, prompting conversation." We also saw information in care plans that was intended to assist staff with understanding the person's needs when they were not able to verbalise these.

Good

Is the service responsive?

We overheard conversations between people who lived at the home and staff and it was clear that staff knew people well, including their likes and dislikes and their individual preferences for care.

We saw that the complaints procedure was displayed within the home and people who lived at the home told us that they would feel quite confident about raising a complaint. One person said, "I would tell one of the carers - touch wood no problems", another person told us, "I would have to go to (the registered manager) and she listens but I don't know how far she takes it" and a third person said, "I would go to the lady in charge - I have sometimes and she sees to it."

Relatives also said that they would not hesitate to complain, although they had not needed to. One person said, "I would see (the registered manager) - no complaints" and another told us, "I'd see (the manager) - she is very approachable - I can't complain about anything".

However, we received varying responses from staff. Some staff felt that senior staff listened but the manager didn't always respond to complaints. One person said, "I feel (the registered manager) is stressed - sometimes when she is informed nothing is done." Another member of staff told us" Yes, (the registered manager) does take it on board; we do report to her and she does act on some."

We checked the complaints log and saw that no complaints had been recorded since May 2013. However, we saw a complaint recorded in one person's care plan; although this had been dealt with in a satisfactory manner, the information had not been transferred to the complaints log. The registered manager was not able to explain this omission.

We saw numerous thank you cards with positive messages stored in the quality assurance folder.

We asked people if they were consulted about how they thought the home was being operated and about the support they received. One person said, "I think I have" but the other three people responded negatively. We also asked if people were kept informed about what was happening at the home. Again, one person said, "If you ask – yes" but the other three people responded negatively.

We saw that 'resident' meetings were held, although these were infrequent. There were minutes available of the meetings held in August and December 2014. We saw that people had been asked for their opinions about the care they received, about activities and about the skills of the staff, and that no issues had been raised.

Requires improvement

Is the service well-led?

Our findings

There was a registered manager in post who had been the manager of the service for a number of years. We asked the manager to describe the culture of the home. They said that there was an 'open door' management policy and that any issues were discussed at meetings, which were a 'two way' process. They told us that the staff who worked at The Willows were 'natural' carers who were aware of the 'personalisation agenda' and the need to treat people as individuals.

We asked staff about the culture of the home. One member of staff said, "Good, brilliant atmosphere" and another said, "Honest and open – the best way to be." Staff told us that there was a good management team, although some staff said that they had more confidence in the deputy manager than the registered manager. It had been recommended in the outcome of a recent safeguarding investigation carried out by the local authority that the registered manager carried out further training on leadership. This has been acted on; the registered manager was undertaking a National Vocational Qualification at Level 5.

We asked to see audits undertaken by the registered manager or general manager to evidence that systems in place at the home were being followed by staff. We saw that care plans were evaluated each month to make sure they were up to date, but there were no audits for medication, infection control or care planning being carried out by the registered manager or a more senior manager. This meant that there was a lack of evidence that systems were being monitored to ensure people received the care and support they required, and in a safe way.

We recommend that audits take place to evidence that systems in place are being used effectively and that action is taken when needed to improve the service received by people living at the home.

Staff told us that satisfaction surveys were distributed to people who lived at the home, to relatives and to staff. They told us that, if any issues were raised in surveys, they tried to make the improvements that were needed. One member of staff said, "If we get criticism, we do try and improve it." We saw the surveys that had been returned from relatives and noted the responses had not been collated and analysed. One person had commented, "The building looks run down" and another person had commented on staff shortages. However, overall comments were positive.

We also saw the surveys that had been distributed to health and social care professionals. Again, there had been no analysis to identify areas that required improvement. However, the responses we saw were positive, and included the comments, "Caring, attentive and helpful staff", "The notes (I required) were ready and appeared full and complete" and "(Staff) are efficient and professional and well supported by the manager."

We saw that five staff surveys had been completed during March and April 2015. One person mentioned poor induction training and another mentioned a lack of social activities. There was no analysis of the returned surveys and no action plan to record areas that had been identified as requiring improvement.

We were told that the cook had carried out some surveys with people who lived at the home about meal provision. However, this information could not be located on the day of the inspection.

Relative's told us that there were meetings at the home they could attend. One relative said, "There has been two or three – they do listen to me and take it on board."

Staff told us that they attended meetings; some staff found these useful and felt that they could "Air their views" although other staff did not agree. One staff member said, "No – staff meeting recently – nothing has been addressed" and another said, "Usually every 6 weeks – waste of time." We saw minutes of meetings that had been held for day staff in December 2014 and April 2015, and for night staff in June 2015. The topics discussed included infection control, the outcome of the previous CQC inspection, staff training, accident recording and refurbishment plans. The minutes recorded that staff had been asked if they had any issues to raise.

We recommend that information gathered in surveys and in meetings is collated and analysed, and the outcome used to improve the service received by people living at the home.

The registered manager recorded in the PIR document they submitted prior to the inspection that there had been learning from the outcome of some recent safeguarding

Requires improvement

Is the service well-led?

investigations. We asked staff if there had been learning from incidents at the home to improve the overall service provided. Two of the three staff were able to describe incidents that had occurred, the investigations that had been carried out and the learning for staff. We also saw that some staff supervision records included information about learning from incidents that had occurred. This showed that the registered manager had listened and had taken action to ensure that staff were aware of any improvements to practice that were needed.

'Champions' had been appointed at the home; there was a dignity champion, an infection control champion and a medication champion. Champions are staff members who take on responsibility for a particular topic. It is their role to share up to date information with the rest of the staff group and to promote their topic within the home.

The refurbishment programme recorded that one double bedroom had been converted into two bedrooms; this had not resulted in any increase in the numbers of people accommodated. We had not been informed of this alteration to the premises by the registered provider. We consulted with the registration team following the inspection and were advised that the registered person should inform the Commission of these changes in a statutory notification, and that their Statement of Purpose should be updated accordingly. This information has since been shared with the general manager.

Overall, record keeping at the home was satisfactory, and records and documents that we asked to see were promptly provided by the registered manager.

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 did not take formal enforcement action at this stage. 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 HSCA (RA) Regulations 2014 Staffing **There were insufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet people's assessed needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The premises used by the service were not suitable for the purpose for which they were being used.**