# The Willows Home Limited

# The Willows

## Inspection report

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## Ratings

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

## Overall summary

The inspection took place on 15 July 2015 and was unannounced.

The Willows is in the village of Rippingale in Lincolnshire. It is registered to provide accommodation and personal care for up to 30 older people or people living with a dementia.

There was a registered manager in post when we visited. 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 Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS)

# Summary of findings

and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect

themselves. The registered manager had assessed people's abilities to make decisions and where people were unable to make decisions the systems in place ensured they were made in the person's best interest. Where there was a risk someone was being deprived of their liberty the registered manager had made applications to the local authority for their needs to be assessed.

Care workers knew how to keep people safe and were happy to raise concerns with the registered manager. They also knew how to raise concerns with the local safeguarding authority. People had been assessed and risks to their health and welfare had been identified. There were systems in place which supported good ordering, storage and administration of medicine.

Staff were safe to work with the people living at the home and there were systems in place to calculate the amount of staff needed to meet people's needs. Care workers received training and support which ensure they had the skills needed to meet people's care needs.

People were supported to eat safely and where people were at risk of choking advice had been sought from healthcare professionals. People were offered a choice of food, however, choice around the midday meal was restricted.

There was a warm and caring relationship between care workers and people living at the home with lots of laughter. Care workers were aware of people's individual communication needs and supported people to make choices. People were involved with planning there care and attended reviews of their care plan to ensure it met their needs.

While people's needs were met with care and kindness, the registered manager had not always identified when the care provided was no longer adequate to support people. Care plans also did not fully identity people's needs or support care workers with information on how to meet those needs. People were not supported to live meaningful lives as care workers did not always have time to maintain an acceptable level of activities.

People living at the home, visitors and staff said that the registered manager was approachable and would work to resolve any issues or concerns brought to their attention. There were systems in place to allow people to comment on the quality of the service and for actions to be taken. However, the registered manager did not audit risks to see if changes to care or the environment would reduce the risks people faced. Care plan audits had not identified that the plans did not fully meet people's needs.

# 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 was safe.

Appropriate checks were completed to ensure staff were safe to work with the people living at the home. There were enough staff available to meet people's needs.

Care workers knew how to raise concerns about people's safety and the registered manager worked with the local authority to keep people safe.

There were systems in place to obtain and administer medicines safely. Care workers supported people to take their medicines.

**Good**

**Is the service effective?**
The service was effective.

Care workers received training and support to ensure they had the skills needed to meet people's care needs.

People were supported to make choices and where they were unable to make decisions the registered manager followed the law to make decisions in their best interest.

**Good**

**Is the service caring?**
The service was caring.

There was a warm and caring relationship between care workers and people living at the home.

People were supported to be involved in planning their care to ensure it was person centred and met their needs

**Good**

**Is the service responsive?**
The service was not always responsive.

People were supported by care workers who knew their needs and met them in a kind and caring way.

Care did not always meet people's needs.

Care workers did not always have the time to support people with interests and hobbies.

**Requires improvement**

**Is the service well-led?**
The service was not always well led.

The registered manager was approachable and responsive to ideas. People living at the home, their relatives and staff were all happy to raise concerns with the registered manager and were confident she would resolve them.

**Requires improvement**

# Summary of findings

The registered manager had not always identified when they could no longer meet people's needs and how this affected the quality of the service people received.

There were some systems in place to monitor the quality of service provided. However, the registered manager did not audit incidents and accidents. Care plan audits had not identified shortfalls in the care plans.

# 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.

This inspection took place on 15 July 2015 and was unannounced. The inspection was completed by a single inspector.

Before the inspection, the provider completed 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. Prior to this inspection we reviewed the PIR and other information we held about the provider.

We spoke with three people who lived at the home and two relatives. Some people had problems with their memory and were unable to tell us about their experiences of living at the home. Therefore, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with a senior care worker, a care worker, the registered manager and a visiting healthcare professional. We reviewed four care plans and looked at the medicine records and the management records for the home.

Good

# Is the service safe?

## Our findings

People told us they felt safe living at the home. A relative said, "I have no concerns about anything." Care workers could tell us that safeguarding was about keeping people safe from harm. They could describe the different types of harm a person could be exposed to and how to minimise the risk. Care workers knew how to report safeguarding concerns both internally and externally. The telephone number to raise concerns directly with the local authority safeguarding team was available to all staff.

The registered manager had correctly contacted the local safeguarding authority when they had concerns. Records showed they had fully investigated any concerns raised by the local safeguarding authority about people who lived in the home and taken appropriate action to keep people safe.

Risks to people's health were considered when planning care. For example, one person who often got up at night was on regular checks. The deputy manager explained that they had considered using a mat linked to the call system to alert care workers when the person got up, but felt that this would increase the person's risk of falling.

People told us there were enough care workers to meet their needs and care workers came quickly when they pressed their call bell. The registered manager had used a staffing tool to calculate the number of care workers required to safely meet the needs of people living at the home. Records showed the registered manager provided more care workers than the staffing tool had identified were required to meet people's needs.

The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw people had completed application forms and the registered manager had completed structured interviews. The required checks had been completed to ensure that staff were safe to work with people who live at the home.

We spent time watching the medicine round and saw that medicine was administered to people in a safe way which reduced the risk of medicine errors. We saw care workers advised people how to take their medicine. For example, if a table needed chewing. A visitor to the home told us their relative had trouble swallowing and care workers ensured that they had swallowed the medicine safely before leaving them.

We saw one person was reluctant to take their medicine, However, the care worker spent time with them, making them laugh and encouraging and supporting them and eventually they took their medicine. Where people consistently refused to take their medicine action was taken. One person told us, "I have tablets but I am refusing to take them. I had the doctor out last week to discuss it." They told us the care workers still offered them their tablets at the correct time each day.

There were systems in place for ordering medicine. However, the registered manager discussed with us concerns they had about one person's medicine which was out of stock. The registered manager had followed this up with the doctor's surgery to discuss the impact on the person and to identify when more medicine would be available. .

Records showed care workers had received appropriate training in relation to supporting people with their medicines.

Good

# Is the service effective?

## Our findings

A relative told us that they trusted the care workers. They said they visited several times a week and knew that care workers would care for people properly when they were not there.

Staff told us they had received an induction to the home which equipped them with the skills needed to meet people's needs. This included time spent with a more experienced member of staff as well as studying important areas of care provision such as infection control. In addition the registered manager had implemented the national care certificate for new care workers.

In addition to training at induction, staff were supported by an ongoing programme of training to maintain their skills and develop new ones dependant on the needs of people living at the home. Staff had also been supported to complete qualifications in care. For example, the senior carer had completed a nationally recognised qualification in care and was in the process of studying for another one in management to support their new role.

Staff told us they received support and guidance from the registered manager in the form of annual appraisals and regular supervisions. They said they received supervisions every eight weeks and could request an extra supervision with the manager any time they had concerns. The provider supported the registered manager with annual appraisals and also spent time with them on a monthly basis discussing the home and any changes needed. Supervision and appraisals provided an opportunity to review staff's skills and identify any training needs.

We saw where people had the ability to make a decision their decisions were recorded and respected. Where people were unable to make decisions for themselves the care plans recorded if anyone had the legal powers to make decisions on their behalf. This meant it was clear who was able to give consent for treatment or if a best interest meeting was required. A best interest meeting is where relatives and health and social care professionals discuss and agree what action to take what is in the best interest of the person receiving care.

Care workers were aware of the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards. These are laws which ensure people rights are protected when they are no longer able to make decisions for themselves. We saw the registered manager had assessed people's abilities to make decisions for themselves. Where people were unable to make a decision and may not have chosen to live in a care home the registered manager had applied for a deprivation of liberty safeguard (DoLS) authorisation to ensure the person's rights were protected.

We saw that advice from appropriate healthcare professionals had been sought to ensure people were safe when they were eating and drinking. People were offered food in line with the advice from health professionals. For example, some people were offered soft food which was safer for them to eat. In addition, people used equipment such as plate guards which enabled them to be independent with eating. Care workers had monitored people's weight and raised concerns with the doctor if they people were unable to maintain a healthy weight.

People were offered a choice of food for breakfast and their evening meal. However, there was only one main meal available at midday. While kitchen staff had a list of people's food likes and dislikes and offered an alternative if a person did not like the main meal of the day, people were not routinely offered a choice. Care workers were knowledgeable about people's eating habits. For example, one person would ask for food all day but never ate much. Care workers knew that they would eat a packet of crisps in the afternoon and liked a yoghurt before bed. People had access to cold drinks and were regularly offered hot drink. Care workers made people hot drinks on request and people did not have to wait for the tea trolley.

We saw people were supported by visiting health professionals and during our visit we saw the chiropodist, community nurse, a doctor and a nurse from the GP practice providing care to people. One health professional told us the home had made big improvements in the last year and was on top of people's health needs.

Good

# Is the service caring?

## Our findings

People spoke highly of the registered manager and the relationship they had developed with them One person told us, "[The registered manager] has been one of the best friends I have had for a long while." People told us the care workers were kind and considerate. One person told us, "The carers are extremely nice I have no complaints what so ever." A relative said, "The carers are so patient."

We saw friendships were supported in the home and one person who had been in hospital was warmly welcomed back by their friends. People told us the registered manager had kept them informed about their friend while they had been in hospital.

One person spoke about how they were moving to a care home nearer their relatives, However, they were worried in case they did not like it as much as The Willows. The registered manager reassured them that it would be good to be closer to family. Furthermore, the registered manager agreed to keep their room available for two weeks so that if they were unhappy in their new home they could return to The Willows. We saw this compromise reassured the person.

Staff communicated well with people to help them feel comfortable about receiving care. For example, the deputy manager asked one person to 'flutter their eyes' at them to help with the drops they had just administered. The person smiled and this was a positive intervention for them. Care plans supported care workers communicate effectively with people. For example, one person chose not to wear their hearing aid and the care plan recorded that care workers were to stand in front of the person and speak clearly. Another care plan recorded that a person forgot words and that care workers needed to give them time to remember the words they needed.

People told us they had been involved in planning the care they needed. Where people were unable to make decisions relatives were supported to input into their care needs. For example, the relative of one person who lacked capacity told us they had attended reviews of the care plan every three months. Where people choose not to be informed about their care plans this was respected. For example, one person told us they did not want to be included in making decisions about their care and they were happy to not see their care plan. They had delegated this responsibility to their family.

People were supported to make choices about their daily lives. For example, a relative told us how

the person they visited chose to have lunch in the lounge area. Care workers described how they offered choices to people. For example, by asking them what they wanted to wear, where in the home they wanted to spend time and if they wanted anything to do.

Care plans supported care workers communicate effectively with people. For example, one person chose not to wear their hearing aid and the care plan recorded that care workers were to stand in front of the person and speak clearly. Another care plan recorded that a person forgot words and that care workers needed to give them time to remember the words they needed.

One person told us their relative liked to be smartly dressed and was always smartly dressed when they visited. Another relative said, "I always like [my relative] to look nice…[My relative] has always been a careful dresser." They told us they were happy how care workers supported their relative with their appearance. Care plans supported people in maintaining their privacy. For example, we saw one care plan recorded that the person liked to see their visitors in private.

Requires improvement

# Is the service responsive?

## Our findings

There was a breach in relation to providing person centred care which met people's needs. Care plans did not always support care workers to meet people's needs, for example, we saw one person's notes recorded they could be display challenging behaviour. There was no plan in place, this meant staff had no guidance on how to appropriately support the person when they displayed this behaviour.

In addition, some people who were not always able to maintain their continence chose not to wear continence pads. While the registered manager and care workers respected this there were no care plans in place to support people to access toilet facilities on a regular basis and no information on what behaviour they exhibited when they wanted to go to the toilet. The registered manager told us one person had accidents on a daily basis in a communal area and often mistook chairs for the toilet. Records showed in the six days before our visit the person had been incontinent in the day room, their bedroom, and other people's bedrooms five times. This behaviour had become accepted by the registered manager and care workers as normal for this person and no changes in care were identified to help this person.

The registered manager and care workers had not reacted appropriately when care workers identified that there was blood in a person's catheter over a number of days. We discussed this with the deputy manager who told us they would follow this up and ensure they took advice from a healthcare professional.

This was a breach of Regulation 9(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were happy with the care they received. One person said, "They couldn't look after me any better." This person told us that they liked to go to bed early and was supported by care workers to do so. Care workers knew about people's needs and could tell us about the individual support people needed. For example, one person was starting to spend more time in their bedroom and needed more encouragement to join with others for meals. They also told us how this person would often refuse tea and biscuits, but knew that if they left them available for the person they would have them.

The registered manager supported people to understand their health needs and be compliant with instructions from healthcare professionals. For example, one person who had just come out of hospital needed to make changes to their diet. We saw the registered manager sat with them and explained the changes and why they were needed. They supported the person to be accepting of the change by explaining they would feel better. They reassured the person that they would make sure they had some treats they could eat.

We saw one person with dementia was content occupying themselves with an activity cushion their partner had made for them. However, other people found that there was not much to occupy them. One person said, I'm sitting here wasting daylight." There was no dedicated activities coordinator and care workers were expected to support people in their hobbies and interests. However, care workers told us they did not get sufficient time to support people with hobbies and interests. They said depending on the day they may have time before tea to sit and chat with people of take them for a walk around the garden.

People told us they knew how to make a complaint and they all told us they would feel comfortable raising concerns with the registered manager or the senior carer. The provider had received two complaints since our last inspection. Records showed the registered manager had completed full investigations of the complaints and had informed the person raising the complaint of the outcome and any actions taken.

Requires improvement

# Is the service well-led?

## Our findings

There was a breach in relation to notifying us of safeguarding incidents. The registered manager had taken appropriate action such as involving the local safeguarding team to ensure people were safe. However, they had not always notified us about safeguarding incidents. It is a legal requirement that provider notifies us of incidents. This meant that we did not receive information which would alert us to identify if people were at risk.

This was a breach of Regulation 18(2)(e) of the Health and Social Care Act 2008 (Registration) Regulations 2009.

People said that the registered manager was approachable, responsive to ideas and always investigated concerns raised. A visiting relative said that the registered manager and care workers kept them informed about their relative's needs.

The registered manager had people's best interests at heart and was supportive of people remaining at the home as their care needs increased. However, they had not always fully recognised when a person's needs had increased to a level where they may no longer able to be met at the home. The registered manager had also not recognised the impact this had on other people living at the home. This meant at times the registered manager and care workers had been unable to provide a high quality service to some people.

Staff told us they would be happy to raise concerns about colleagues working practices if they felt something was wrong. Staff told us they trusted the registered manager and that the registered manager listened to them and made changes. One member of staff told us, "You can tell her things and she will try her hardest to resolve them." There was a whistleblowing policy in place and staff knew this protected their rights if they raised concerns within the home to the provider or registered manager.

The provider completed maintenance audits and made any repairs as and when needed. This was evident in the good level of presentation throughout the home. For example, the registered manager identified that one person's call bell was not working properly. They arranged for maintenance person to mend the bell. They informed the person about the issues and told them how they could summons help while the bell was being mended.

The registered manager had surveyed people living at the home, visitors and staff to see what they thought of the service provided and if there were any improvements needed. The registered manager had reviewed the survey results and items identified for further action were discussed at both resident and staff meetings. For example, at a staff meeting on 15 June 2015 they discussed having key workers and a social committee and at a residents' meeting on 18 June they discussed the menu and activities. Relatives told us that people living at the home were invited to regular meetings to discuss the quality of the service they received and any changes they wanted implemented.

There were a number of audits in place to ensure the smooth running of the home. For example, the registered manager was in the process of completing an infection control audit which had been discussed at the local infection control network. In addition the provider visited once a week to support the registered manager and complete their own audit of the environment. However, the registered manager did not routinely review accidents and incidents to identify if there were any trends occurring. They told us they were aware that this was an area they needed to improve. They told us they were working with the local health community to improve care in areas such as preventing pressure sores and reviewing trends was part of the work programme they were completing. In addition care plan audits did not identified the gaps in care plans relating to individual needs.

While at times there was an unpleasant odour about the home, visitors and health care professionals told us the registered manager was working hard to reduce the smell and there had been considerable improvement over the last year. Carpets had been replaced when needed and were regularly cleaned.

We saw the registered manager worked in collaboration with other healthcare professionals to ensure they met people's needs. They also engaged with external organisations to ensure that the care provided met national best standards. The registered manager had also arranged for the home to be involved in a project run by the National Institute of Health Research. This gave them access to the latest guidance for dementia care and meant that they were supporting research into the condition. They

Requires improvement

# Is the service well-led?

were also working in partnership with the local GP practice to reduce admissions to hospital. This meant more support for people to stay in their home when they were ill which was better for the person.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements 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 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>How the regulation was not being met:<br><br>Care was not always planned or delivered to meet people's needs.<br><br>Regulation 9 (1) (b) and 9(3)(b). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents<br><br>How the regulation was not being met:<br><br>The provider had not notified us of safeguarding incidents.<br><br>Regulation 18(2)(e) |