The Willows Residential Care Home 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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
The Willows provides accommodation with personal care for up to 32 older people, including people living with dementia. It does not provide nursing care. Accommodation is provided in one adapted building. During our inspection visit 23 people lived at the home.

People's experience of using this service and what we found
Governance systems, management and provider oversight continued to be inadequate due to the number of improvements still required. A new manager was in the process of registering with the CQC at the time of our inspection visit. Systems and processes designed to identify areas of improvement continued to be ineffective. Conditions we had placed on the provider's registration following the last inspection had not been met. Audits and checks completed by the provider had not identified the concerns we found. This demonstrated the providers systems continued to require improvement. The care planning system was in the process of being changed which meant people's care plans did not always provide sufficient detail or information to support staff in delivering person centred care.

People told us they felt safe, but they did not always receive safe care or were placed at risk of unsafe care. Risks associated with people's care were identified, but care records remained unclear about how risks needed to be managed to demonstrate consistent and safe practice. There had been improvement of infection, prevention, and control practice. Action to improve the fire safety in the home was ongoing to enable the home to be fire safe.

Sufficient numbers of staff were on duty to meet people's needs. Some staff training was in need of updating but staff had access to training to update their skills and competence to ensure they were able to provide safe care consistently. People and relatives gave mixed views of their experiences of care but were positive in comments about staff. Relatives felt people's basic needs were met. Medicine management remained in need of improvement to ensure people's healthcare needs were managed effectively.

People were supported to have some choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always fully support this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 22 February 2022) and there were multiple breaches of the regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

We undertook this focused inspection to check the provider had followed their action plan and to confirm they met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained Requires Improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Willows on our website at www.cqc.org.uk.

Why we inspected
This inspection was a planned inspection based on the previous rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified continued breaches in relation to risks associated with people's care, and management oversight of the service. The provider had not ensured systems and processes in place to monitor the quality and safety of the service were always effective to continually drive improvement. The conditions imposed on the providers registration at our previous inspection in relation to quality and safety have therefore remained in place.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well led findings below.

The Willows

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors.

Service and service type
The Willows is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Willows is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager was in post and had submitted an application to register which was being assessed.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
Inspectors spoke with people during the visit and with relatives on the telephone following the inspection visit to gather feedback on their experience of the service. We spoke with 5 people who used the service and 2 relatives/visitors about their experience of the care provided. Due to people living with dementia, most people were unable to talk with us in detail about the care they received, or the quality of the service provided. Therefore, we used other methods to understand what it was like to live at The Willows. This included observing how staff supported people to help us understand people's experiences of living at the home. We spoke with 6 members of staff including the deputy manager, plus the provider of the service. We reviewed a range of records. This included 4 people's care records, and multiple medication records. We looked at 2 staff files in relation to recruitment and staff supervision. A variety of records related to the management of the service, including policies and procedures were reviewed. After the inspection we continued to seek clarification from the provider and registered manager to validate evidence found. We looked at a variety of records the provider had shared with us in relation to quality assurance and risk management.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Requires Improvement. At this inspection the rating for this key question has remained Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Risks continued not to be identified, monitored and managed effectively.
- One person at risk of falling had been prescribed pain relief medicine but we saw this did not manage their level of pain which increased the risk of them falling. When they called out for staff support when independently mobilising, we were concerned they were going to fall. The person told us, "I am in a lot of pain. I did see the doctor…I need more, more to stop the pain. It's making my life a misery." Following our request for this to be addressed, additional pain relief was sought from the GP.
- Accident records did not clearly document actions taken following falls to help prevent the risk of them happening again. We were told one person had been referred to the falls clinic but there was no evidence to show this had happened. Staff were unable to locate a falls care plan for this person to guide staff in managing the risk. This placed the person at risk of receiving inconsistent or unsafe care.
- Risks associated with people's health conditions and resulting behaviours were not effectively managed. For example, one person had accessed kitchen items that could cause harm to them and others. There were no instructions for staff to record how often the person requested the items or for staff to record what was happening prior to these incidents to try and identify the triggers. There were no suggestions what could trigger the person's anxiety to support staff in managing the resulting behaviours.
- Nutritional risks were not always effectively managed because instructions in care records for staff to follow were not clear. One person was to have restricted fluids due to a health condition, so this did not cause them ill health or harm. Records showed there was one occasion this instruction had not been followed.
- Temporary staff did not have full access to records to ensure they were fully aware of all risks associated with people's care so they could support people safely. One temporary worker told us, "No, I haven't seen anything written. I was introduced to [Name of person] and the seniors and other staff told me what to do." This has subsequently been addressed by the provider.
- Fire risks were not consistently managed. Three bedroom doors were wedged open all day presenting a

fire risk as these would not close automatically in the event of a fire. Risk assessments in place did not address this risk.

Using medicines safely
● Processes to support safe medicine practice continued to require improvement.
● Prescribing instructions were not always followed. A pain relief gel was being applied to a person's skin daily by staff when instructions stated this should not be applied daily.
● Covert medicine (medicine given in disguise) was not administered as agreed and prescribed by health professionals to ensure this was given safely and did not impact on the persons food and fluid intake. The provider told us GP agreement on how this was administered was sought following our inspection.
● Medicine audits had not been effective in identifying discrepancies. For example, one person had more medicine left than they should have which indicated the person may have not received their medicine as prescribed.

Systems and processes to safeguard people from the risk of abuse
● Systems to protect people from the risk of abuse were not always effectively managed to keep people safe.
● One person told us about an incident that had caused them harm. There was no evidence this had been investigated to provide assurance risks to the person's health and safety had been managed to keep them and others safe. Action was taken following our visit to address this and report this to us.
● At the time of our inspection visit we were made aware of a safeguarding concern regarding a person who had fallen. Due to an ongoing safeguarding investigation we did not look into this further but will monitor the outcome.
● Staff were aware of their responsibility to safeguard people from harm and report incidents of concern to management. However, records completed following incidents were not kept in a central location to give an overview and ensure changes in practice and lessons learned were identified to prevent any ongoing risks of harm.

We found evidence of continued risks related to people's health, safety and wellbeing as well as risks related to medicine management. This was a continued breach of regulation 12 (Safe Care and Treatment) 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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● The service was working within the principles of the MCA. Where appropriate legal authorisations were in place to deprive a person of their liberty.
● Staff recognised where people needed support to make decisions. One staff member told us, "Most people can make simple decisions. Like choosing tea or coffee. I show people choices so they can pick. Some people have dementia and they can't make big choices."

Staffing and recruitment

● There were enough staff available to support people's needs and staff had been recruited safely. Staff had access to training, but some staff needed to complete or update their training, so they had the skills and competence to support people safely. A staff member told us further training was needed for staff to help them be effective in their role.

● A staff member told us, "I think people are safe yes, there is enough of us to keep people safe. An extra pair of hands would be good, but it is safe."

● People told us there were enough staff to support their needs. One told us, "Seems to be enough staff about, we do get new ones that come and go, temporary type ones. Sometimes staff are sick, and the other ones are more busy but it hasn't affected me."

● Staff recruitment files confirmed the provider completed checks to ensure staff they employed were safe and suitable to work with people. This included Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● We saw staff were engaged in supporting people throughout the day and were in communal areas to support people when needed.

Preventing and controlling infection

● We were somewhat assured that the provider was using PPE effectively and safely. On our arrival at the home a staff member answered the door not wearing a face mask in line with the providers expectations to prevent the risk of potential infections spreading. Action was taken to address this.

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Dirty linen was not always stored safely in line with best practice and a mattress in use was ripped which meant it was difficult to clean. The provider had plans in place to replace some floor coverings to ensure they could be easily cleaned.

● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed. Whilst this had improved since our last inspection some staff wore jewellery including watches and bracelets which was an infection prevention and control risk.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

Suitable arrangements were in place to enable visitors to the home. Telephone communication had also been used for people to keep in touch with relatives when visiting had not been possible.

Learning lessons when things go wrong

● The provider had not learned lessons to ensure the overall quality and safety of the service sufficiently improved. Our inspection findings demonstrated audits remained ineffective.

● Staff had completed accidents and incident records. However, there was an insufficient system to record and analyse these to enable any areas of improvement to be identified and lessons learned.

● Staff were recording people's weights but there was no audit in place that recognised most people had lost weight (albeit small amounts in some cases). This suggested there may be a need to review people's nutritional intake. Action was taken following our inspection to address this.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Inadequate. At this inspection the rating for this key question has remained Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider's quality monitoring systems and processes were not effective and did not support continuous improvement. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- This is the fifth time the provider has been in breach of Regulation 17. Systems and processes to assess and monitor the safety and quality of the service remained ineffective.
- The provider had failed to effectively identify risks and areas of improvement needed within the monthly reports they submitted to us. The reports are required to demonstrate compliance with the conditions we had placed on their registration following a previous inspection. Reports failed to provide assurance audits had been completed effectively. Lessons had not been learned.
- The providers care planning system was not sufficient. Not all staff had access to care records. Staff who had access to electronic records were unsure how to extract information from them to monitor people's health. Temporary staff relied on permanent staff to tell them about people's care needs. This placed people at risk of unsafe care.
- The providers auditing systems failed to recognise instructions in care records were not always followed to keep people safe. For example, one person's fluid intake care plan needed to be reviewed monthly but had not been reviewed since July 2022. There was an action for staff to call emergency services if a person exceeded more than a specific amount of fluid each day. It was not evident this instruction had been followed when the amount had been exceeded.
- Fire risks were not effectively managed because the provider failed to ensure procedures in place were safe. For example, it was not evident staff were told to remove wedges from bedroom doors to enable the doors to close in the event of a fire.
- The provider did not have a clear system in place to analyse accidents and incidents. This was important so that patterns, trends, and the need for any referrals to other agencies, could be identified to help protect people from repeated risks of potential abuse or harm.
- Quality monitoring systems had not identified people did not always receive person centred care to meet

their needs. For example, we identified risks associated with people's nutritional management and pain management that were not effectively managed.
● There were no working locks fitted to toilet doors to ensure people's right to privacy was respected. This had not been identified and further demonstrated quality monitoring systems were not effective.

Governance systems and processes were not operated correctly to continually drive improvement of the service. This was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008

● The provider was implementing a new electronic care reporting system and was in the process of transferring care records to this system to help improve care planning systems. Staff training on the system was to be arranged.
● A registered manager was not in post, but the provider had taken steps to recruit a manager and they were working at the home at the time of our visit. Their application had been submitted to us for processing, and following our visit, registration was granted.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others
● The provider understood the need to be open and honest when things went wrong. However, the provider had not always identified when this had happened. They told us of planned changes to help them improve their oversight of the service.
● The provider worked with the health and social care professionals involved in people's care so they could support people's physical health and wellbeing.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and their family members had some involvement in decisions relating to people's care to ensure their needs, including any disabilities or religious needs, were fully considered and met. Staff knew people well.
● We received mixed comments from people and their relatives in regard to the care and service provided at the home. A relative told us, "The care is adequate, the girls all seem to be caring."
● People told us, "I think the managers do the best that they can here, and "The staff are good to me... but this place is not my thing" (they went on to explain this was because they were unable to engage with people due to their needs).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured risks associated with people's care, and the environment were always identified, assessed and mitigated. Regulation 12 (1)

The enforcement action we took:

Varied the conditions placed on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place were not effective to assess, monitor and improve the quality and safety of the service provided. The provider had not ensured, timely improvements to the service were made, and sustained. Regulation 17 (1)

The enforcement action we took:

Varied the conditions placed on the providers registration.