Culpeper Care Limited

Willow Tree Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Willow Tree Nursing Home is a care home registered to provide nursing care and accommodation for a maximum of 47 people. The home is located in a residential part of Hillmorton in Rugby and most of the bedrooms are on the ground floor. There are seven bedrooms on the first floor but this floor was not occupied during this visit. There were 31 people living at the home at the time of our visit, some of whom were living with dementia.

People's experience of using this service and what we found
Risks associated with people's care were not always managed well and governance systems to monitor the quality and safety of the service required improvement. Some areas requiring improvement had been identified prior to our visit, but remedial action had either not been taken or was not effective. Learning from adverse accidents and incidents was not routinely shared with staff.

We received mixed feedback from staff about the leadership of the service. Whilst some staff felt supported, other staff felt their concerns or issues were either not listened to or not dealt with effectively. Staff needed more confidence and motivation to check the quality of their own work and challenge poor record keeping. The provider recognised communication between staff and the management team was an area for improvement.

There were enough staff on duty to meet people's needs, but staff told us there were occasions when staffing levels were too low to provide responsive care. The registered manager assured us staffing levels were safe, but acknowledged some staff worked more effectively together in meeting people's individual needs.

Improvements were needed in the management and recording of medicines in the home.

Safeguarding procedures were in place to protect people and staff understood their responsibilities to keep people safe. Action had been taken to improve the cleanliness of the home and staff had access to protective equipment in line with current guidance.

The provider welcomed our inspection feedback. They assured us they were committed to providing high quality care and had already started to implement resources to support the registered manager and improve the governance and leadership of the home.

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

Rating at last inspection
The last rating for this service was good. (Report published 16 June 2018).

Why we inspected
The inspection was prompted by concerns we had received about the management of risks, failure to address concerns and the overall governance of the service. As a result, a decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of 'Safe' and 'Well-led' only.

The overall rating for the service has deteriorated to requires improvement. This is based on the findings at this inspection.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified two breaches of the regulations in relation to the safety of people's care and the management of the service.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information, we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our Safe findings below.

Is the service well-led?

Requires Improvement

The service was not always Well-led.

Details are in our Well-led findings below.

Willow Tree Nursing Home

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by four inspectors and two assistant inspectors. Two inspectors visited the home. One inspector gathered information from the manager via email and the other inspector and two assistant inspectors spoke with staff and relatives over the telephone.

Service and service type
Willow Tree Nursing Home is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
Our inspection was announced. We gave the service 30 minutes notice of our visit because the service was inspected during the coronavirus pandemic and we wanted to be sure we were informed of the home's coronavirus risk assessment for visiting healthcare professionals before we entered the building.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection and recurrent themes of concerns. We sought feedback from the local authority and health professionals who work with the service. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who lived at the home about their experiences of the care provided. We spoke with the registered manager, the area operations director, the home support manager, a consultant employed by the provider to support the home and the nominated individual.

We did limited observations of the care people received in communal areas. We reviewed three people's care records and four people's medicine records. We looked at a sample of records relating to the management of the service including training data, improvement action plans, health and safety checks, policies and procedures and a sample of completed audits and checks. We also reviewed three staff personnel files to check staff had been recruited safely.

After the inspection
We spoke with six people's relatives and nine staff members via the telephone. We reviewed the additional documentation we had requested from the registered manager during the site visit. We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. 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; Using medicines safely; Lessons learned

- Information we received prior to our visit indicated people did not always receive safe care because some risks associated with their safety were not managed well.
- Care plans described individual risks but there was a lack of oversight to ensure risk management plans were consistently followed.
- Following a recent incident in the home, two people had been placed on 30 minute observations so staff could be sure of where they were in the home. Staff were not aware of this increased level of observation. One staff member told us, "We check on everybody quite regularly, but I can't think of anybody specifically." Another said, "On the dementia unit there are a few people on hourly checks as well as [name of one of the people]."
- Some people identified as at high risk of developing skin damage had pressure relieving mattresses on their beds. The provider had a system to ensure the mattresses were on the correct setting for people's weights. However, the system was not effective because we still identified several mattresses which were not on the correct setting. For example, one person's mattress was set to support a weight of 110kg when the person's weight was 51.9kg. Another person's mattress was set at 80kg when the person's last recorded weight was 35.9kg. It is important mattresses are at the right setting to effectively relieve pressure and help prevent sore areas from developing.
- There were gaps in the records staff completed to demonstrate how they minimised risks to people developing damaged skin. Records did not demonstrate people received regular pressure relief because there were significant gaps in repositioning charts.
- Risk management plans were not consistently reviewed following incidents to ensure people were kept as safe as possible. In August 2020 one person had fallen but their falls risk assessment had not been reviewed or updated following the incident to minimise the risk of this happening again.
- In order to manage the risks of introducing Covid-19 into the home, staff had been using a thermometer to take their temperatures so any high readings associated with Covid-19 symptoms could be identified and appropriate actions taken. For 12 days during August 2020 there were large fluctuations in the temperatures staff recorded which questioned the accuracy or correct usage of the electronic thermometer. The records had not been reviewed by the registered manager to identify the discrepancies. Staff had failed to recognise the risk of inaccurate readings leading to staff with high temperatures working in the home. When we brought the inaccuracies to the notice of the registered manager, their checks confirmed the thermometer had regularly been used on the wrong setting.
- Effective processes were not in place for the timely ordering of medicines. We identified one person's prescribed medicine had run out two days prior to our inspection visit. No action had been taken to order the medicine until we raised it with one of the clinical staff.

● One person was prescribed a medicine to manage their pain on an 'as required' basis. Staff had not recorded the date, time and reason when this was administered. This meant the provider could not assure themselves the person's medicine was managed in accordance with prescribing instructions.
● One person was prescribed a medicine to be given via a transdermal patch to be applied directly to their skin. It is important the patches are rotated around the body to avoid people experiencing unnecessary side effects. Rotation charts showed where patches had been applied, but they did not always show the old patch had been removed. Records of daily checks to ensure the patches were still in place had not been consistently recorded.
● The provider had identified improvements were required in medicines management in the home, particularly in maintaining the accuracy of medicines administration records.
● Staff told us learning from adverse accidents and incidents was not shared with them. One staff member said, "I don't know if investigations are carried out properly. We know when things have happened but then we don't really hear anymore, just that an accident has happened. I never really feel like you know the result." Another said, "We do know when incidents have happened, but we never hear about outcomes or anything being altered."
● Where serious incidents had occurred the investigations completed and root cause analysis were not detailed enough to provide assurance all risks had been identified to minimise further risks. The registered manager acknowledged they needed further training in this area.
● Accidents and incidents were monitored and analysed by the registered manager but the analysis was not always clear as to where or at what time an accident or incident had occurred. This meant it was not possible to identify trends or themes at service level.

We found no evidence that people had been harmed however risks associated with people's care were not effectively identified and managed to keep people safe. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Prior to our inspection we received information that people did not always have their own slings or slide sheets and there was a lack of continence pads in the home. We found no evidence to substantiate these concerns. Staff told us, "We do have equipment to move people; they have their own slings and belts and we have done training recently" and, "People have their own slings; there is one sling per resident, and these are washed and dried overnight if needed."

Staffing and recruitment
● Enough staff were on duty during our visit to respond to people's needs in a timely way.
● However, staff told us there were occasions staffing levels were too low. One staff member told us, "It can be very stressful. [It is] mainly staffing levels which impacts on staff morale and I worry that people don't get the care they need. There are numerous times when people don't receive personal care. It's not the staff's fault there is just too much to do." Another explained staffing levels had reduced because there were less people in the home. They stated, "Now we're getting more residents, but staffing hasn't increased and it's hard to cover especially at weekends. Trying to cover with agency on the same day is almost impossible. I don't think it's on purpose, but it is difficult to meet everyone's needs. We make sure people are safe but there's not a lot more we can do."
● One person told us they often had to wait for support with personal care and commented, "They are very slow coming to help; they never used to be like that."
● We shared the feedback we had gathered with the registered manager following our inspection visit. The registered manager explained staffing levels were determined by people's assessed needs and shared the dependency tool they used to determine required staffing levels with us. The tool showed staffing levels met

what the provider felt were required. The registered manager assured us staffing levels were safe but acknowledged some staff worked more effectively together than others in meeting people's individual needs.

Safeguarding

● Staff understood their responsibilities to protect people from the risk of abuse. One staff member told us, "If someone wasn't safe, I would speak to the manager. She would report it to safeguarding and investigate it." A third staff member told us, "I actually raised a safeguarding recently and was supported to do so by the registered manager."

● However, we found safeguarding checks around agency staff needed to be improved. There were gaps in the profiles for some agency staff to evidence safe recruitment checks had been followed and they had the necessary skills and experience. We brought this to the attention of the provider's nursing consultant.

Preventing and controlling infection

● Prior to our inspection we had received concerns about the cleanliness of the home.

● The home was clean and there were no unpleasant odours on the day of our inspection visit. However, cleaning schedules had not always been completed to confirm the home was always cleaned in accordance with the provider's policies and procedures.

● Staff had completed infection prevention training and followed good infection control practice during our visit. Staff had access to, and were seen to use, protective equipment such as disposable masks and gloves in line with current guidance.

Requires Improvement

Is the service well-led?

Our findings

Well led

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Information we received prior to our visit indicated the service was not consistently well-led.
- We found risks associated with people's care were not always managed well and governance systems to monitor the quality and safety of the service required improvement.
- Some areas requiring improvement had been identified by the provider prior to our visit but remedial action had either not been taken or was not effective. For example, since April 2020 monthly audits of pressure relieving mattresses had identified they were not always at the correct setting to effectively relieve pressure. At this inspection we identified the same issue. There were no recorded actions as to how this was to be addressed.
- The provider's medication audits had identified issues with the recording of the administration of medicines. For example, in July there were 75 gaps on medicines administration records where staff had failed to sign to confirm they had given people their medicines. Subsequent audits had identified that limited improvements had been made.
- Tools to manage and minimise risks were not used or implemented effectively. The provider used safety crosses as a visual data collection tool to improve people's safety and promote good practice in areas such as the management of falls and pressure injuries. The safety crosses were not being completed as required by the provider.
- Each month the registered manager completed an 'adverse incident report' from which a risk reduction plan was developed. The plan lacked detail and there was no information about who was responsible for implementing any required actions and by what date they should be completed. This meant there was no ownership of actions to drive improvement in the home.
- Communication needed to be improved between management staff and the provider. During the inspection, we shared information with the provider about an incident in the home of which they were not aware. The provider told us they would investigate the matter further so they could be assured necessary actions had been taken in accordance with their disciplinary policies and procedures.

The provider failed to operate effective systems and processes to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The nominated individual and area manager told us they wanted to provide high quality care and had already identified that the governance and leadership within the home needed to improve. The nominated individual commented, "We are willing and able to put the resources into the home to make it a home we can be proud of."
● The provider had appointed a 'nurse consultant' to provide the registered manager with support and guidance. The consultant had completed audits of infection control and medication and introduced tools to manage risk. These tools and actions needed to become embedded within the culture of the home and the practice of staff to ensure people consistently received positive outcomes.
● The provider was recruiting a deputy manager as they recognised the daily oversight of the home needed to be improved.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The management team had not always met their responsibility to be open and honest when things had gone wrong. We had been made aware of two incidents when a relative had not been informed about an adverse incident impacting on their family member. One incident was being dealt with through the provider's formal complaints process, but the other one had not been addressed with the relative. The provider had not been made aware of this second incident and assured us they would fully investigate it.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Communication within the service needed to be improved. Despite the provider having their own systems for staff to share concerns, some staff had chosen to escalate their concerns to us, the Care Quality Commission, because they did not always feel listened to. One staff member told us, "I think it would be difficult to whistle blow. I would use the policy if needed, but I don't think we would be supported There is a culture that if you speak out about problems you are seen as a trouble maker." Another commented, "When I have raised concerns [registered manager] says she can't address them because it's a cultural thing, and nothing gets done about it." However, another staff member told us, "[Registered manager] is responsive to concerns and issues."
● We received mixed feedback from staff about the atmosphere within the home. Some staff spoke of a 'good team atmosphere' and told us they received the training and support to carry out their role effectively. Other staff were not so positive. One staff member told us, "There are staff cliques and there aren't enough of us so we don't really pull together as a team." Another said, "Not everyone works as a team, and it can be exhausting."
● Staff lacked confidence and motivation to check the quality of their own work and that of their peers. Poor record keeping was not always challenged or reported.
● Relatives spoke positively about the service and most felt fully informed, particularly during the COVID-19 visiting restrictions. Comments included: "The staff are very caring, it's very moving how staff treat people", "They are genuinely caring people" and, "They give really good care and the carers do a good job."

Working in partnership with others
● The provider welcomed the feedback from our inspection and assured us action would be taken to address the areas of shortfall we found.
● The provider was working with other organisations to support the management and development of the service.
● The provider's nominated individual had planned a meeting with staff to give them the opportunity to discuss their concerns and to give them the opportunity to speak directly with him.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not adequately assess and protect people against risks by doing all that was practicable to identify and mitigate such risks.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider's systems and processes were not operated effectively to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

We issued a Warning Notice.