

Holt Green Residential Homes Limited

Willow Lodge

Inspection report

15-16 Moss View
Ormskirk
Lancashire
L39 4QA

Tel: 01695579319

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Inadequate 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Willow Lodge Nursing Home is located in a residential area of Ormskirk, close to the town centre and all local amenities. The home provides support for up to 22 people who require assistance with personal or nursing care needs and who are living with dementia related conditions. Accommodation is available in both single and shared facilities on two floors served by a passenger lift and stairs. There are spacious communal areas available including lounges, dining areas and two conservatories. There is parking to the front of the property and a safe garden area to the rear of the home.

The last inspection of this location was conducted on 26 October 2015 and 6 November 2015, when we found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to safe care and treatment, premises and equipment, dignity and respect, person-centred care and good governance. We served a warning notice in relation to none compliance with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We did not receive any representations from the provider. Actions the provider took in response to our findings at the last inspection are identified below.

This inspection was conducted on 6 December 2016 and it was unannounced, which meant that people did not know we were going to visit the home.

The registered manager was on duty at the time of our inspection. 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 of the Health and Social Care Act and associated regulations about how the service is run.

At our last inspection on 26 October 2015 and 6 November 2015 we found the registered provider had not ensured systems and processes had been established to effectively assess, monitor and mitigate risks relating to the health, safety and welfare of service users. Therefore, this area was in need of improvement, so that the service could be sufficiently monitored under a continuous assessment process and any improvements needed could be identified and addressed in a timely fashion.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions would be completed by 15 April 2016.

At this inspection we found that quality monitoring systems had been implemented, but these had not always identified shortfalls recognised by the inspection team and therefore they were not consistently effective, particularly around medication management, where we found some significant shortfalls. Therefore, this constituted as a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 26 October 2015 and 6 November 2015 we found that the registered person had not ensured that the premises were properly maintained throughout. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions in relation to the premises were on-going.

During the course of this inspection we toured the premises and found that significant improvements had been made to the environment. Several areas of the home had been decorated, upgraded and modernised. More suitable flooring had been installed in the lounge area and new furniture had been purchased, including profile beds. The laundry department had been upgrade. Therefore, the breach of regulation 15 had been met.

At our last inspection on 26 October 2015 and 6 November 2015 we found that the registered person had not ensured that people were consistently treated with dignity and respect. This was because we observed several poor care practices during our inspection. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions would be completed by 31 January 2016.

At this inspection we found the environment to be calm and staff members were interacting well with those who lived at Willow Lodge. People looked happy and interested in day to day activities. We did not observe any failings in relation to privacy and dignity. Therefore, the breach of regulation 10 had been met.

At our last inspection on 26 October 2015 and 6 November 2015 we found that the registered person had not ensured that the plans of care always reflected people's current needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that action would be completed by 31 March 2016.

At this inspection we found the care planning system had improved. It was well structured and, in general person centred. The plans of care had been reviewed regularly and any changes in need had been recorded well. However, we found that not all assessed needs had been recorded within the plans of care. Therefore, this constituted as a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 26 October 2015 and 6 November 2015 we found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because medicines were not being well managed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a warning notice, as there were significant shortfalls in relation to medicines management. The provider sent us their action plan, which showed that action would be completed by 31 March 2016.

At this inspection we found continuing significant concerns, in relation to the safe management of medicines. Therefore, this constituted as a continued breach of regulations 12. At our last inspection on 26 October 2015 and 6 November 2015 we found that the registered provider had failed to assess and identify risks to the health and safety of people who used the service and had not done all that was reasonable practicable to mitigate such risks. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us their action plan, which showed that actions would be completed by 31 March 2016.

At this inspection we found that a wide range of risk assessments had been introduced in relation to

people's health, safety and welfare. However, the information was not always linked closely with the plans of care and therefore strategies implemented in order to reduce potential harm were not always evident. We also found that assessments had not always been developed in relation to some areas of identified risk, such as behaviours that challenged the service. We were told by the registered manager that plans were in place to dismantle the conservatory, which was currently serving as a dining room, as it did not promote a pleasant dining area for those who lived at the home. We also found that several bedroom doors slammed shut and were in need of adjustment, in order to prevent entrapment injuries and one bedroom door did not fit properly into the door frame. Therefore, the findings above constituted a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 26 October 2015 and 6 November 2015 we found that the registered provider had not protected people against the risk of receiving inappropriate or unsafe care and treatment because infection control practices were poor. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us their action plan, which showed that actions in this area were on-going.

During this inspection we found that significant improvements had been made to the environment. The home was warm and comfortable throughout. There were no unpleasant smells noted and the home was clean and hygienic throughout. Therefore, this part of the breach of regulation 12 had been met.

At our last inspection on 26 October 2015 and 6 November 2015 we found that the registered provider had not protected people's health and safety because they had not ensured that persons providing care or treatment to service users had the competence, skills and experience to do so safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us their action plan, which showed that actions in this area were on-going due to continual training.

At this inspection we found that a varied training programme had been introduced for the staff team, which helped them to keep abreast of current practices and any changes in legislation. Regular supervision sessions for staff and annual appraisals were also being conducted. Therefore, this part of the breach of regulation 12 had been met.

Fire procedures were easily available, so that people were aware of action they needed to take in the event of a fire and records we saw provided good information about how people needed to be assisted from the building, should the need arise. Records showed that equipment and systems within the home had been serviced in accordance with the manufacturer's recommendations. This helped to protect people from harm.

Records showed that Mental Capacity Assessments had been conducted, in order to determine capacity levels. The rights of people were protected as applications to deprive someone of their liberty for their own safety had not been obtained for restrictive practices. People's privacy and dignity was consistently respected.

The service had reported any safeguarding concerns to the relevant authorities and suitable arrangements were in place to ensure that staff were deployed, who had the necessary skills and knowledge to meet people's needs safely. A range of training for staff was provided.

Recruitment practices adopted by the home were robust. Appropriate background checks had been conducted, which meant that the safety and well-being of those who used the service was adequately

protected. New staff were supported through a detailed induction programme.

People we spoke with were aware of how to raise concerns, should they need to do so. A complaints procedure was in place at the home and a system had been implemented for the recording of complaints received.

The service worked well with a range of community professionals. This helped to ensure that people's health care needs were being appropriately met.

People we spoke with were complementary about the staff team. They felt that they were treated in a kind, caring and respectful manner. People expressed their satisfaction about the home and the services provided.

Regular meetings were held for the staff team. This enabled those who worked at the home to discuss topics of interest in an open forum. People's views were also gained through processes, such as satisfaction surveys.

We found breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to safe care and treatment, person centred-care and good governance.

You can see what action we told the provider to take at the back of the full version of this report.

Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

This service was not always safe.

Recruitment practices adopted by the home helped to ensure that only suitable staff were appointed to work with the vulnerable client group.

Improvements to the environment were noted. The home was clean, hygienic and pleasant smelling throughout. Many areas had been upgraded and decorated. However, some doors within the home slammed shut and therefore could potentially cause entrapment.

Risks assessments were in place. However, these were not always linked to the plans of care and some areas of risk had not been appropriately assessed. Medicines were not well-managed.

Safeguarding referrals had been made to the relevant authorities and emergency plans had been generated, so that people were kept safe. Staff members were aware of the procedures to follow should they have concerns about the welfare of those who lived at the home.

Is the service effective?

Good 

This service was effective.

Records showed that staff received a good induction programme when they started to work at the home. This was followed by a range of training programmes, regular supervision and annual appraisals.

Mental capacity assessments had been conducted, in accordance with the Mental Capacity Act. Deprivation of liberty Safeguard approvals had been requested on behalf of those who lacked the capacity to make specific decisions and who were being restricted in any way. The information recorded was very detailed.

The premises were, in general satisfactory and meal times were being well managed.

Is the service caring?

Good ●

This service was caring.

Staff were seen to be kind, caring and respectful of people's needs.

Those who lived at Willow Lodge were supported to be involved in the day to day activities of the home and were enabled to access advocacy services, should they require this.

Records were retained in a confidential manner and people's privacy and dignity was consistently respected.

Those who stayed at the home were supported to maintain their independence, as far as possible and staff members, in general communicated well with those in their care.

Is the service responsive?

Requires Improvement ●

This service was not consistently responsive.

The plans of care were based on assessments of people's needs and they were, in general person centred and well written documents. However, assessed needs were not always incorporated into the planning of people's care.

Activities were provided. Staff could support people to maintain their individuality and to participate in a choice of activities.

Complaints were being well managed

Is the service well-led?

Requires Improvement ●

This service was not consistently well-led.

The home had developed methodologies for assessing and monitoring the quality of service provided. However, the auditing system had not consistently identified areas in need of improvement, as recognised by the inspection team.

A wide range of policies and procedures were in place, However, these could have been reviewed and updated, to ensure current guidance was provided by the staff team.

Management meetings were held and meetings for the staff team were evident. This allowed important information to be disseminated and so that those who worked at the home could discuss any relevant topics in an open forum.

Willow Lodge

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 had addressed the breaches identified at the previous inspection, if they were 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 new rating for the service under the Care Act 2014.

This inspection was unannounced and was conducted by two Adult Social Care inspectors from the Care Quality Commission (CQC). At the time of our inspection there were 19 people who lived at Willow Lodge. Due to those who lived at the home being affected by dementia related conditions, it was not possible to converse with many of them. However, we were able to gather feedback from three people who lived at Willow Lodge and four relatives. We received positive comments from those we spoke with.

We also spoke with four members of staff and the registered manager of the home. We toured the premises, viewing private accommodation and communal areas. We observed the day-to-day activity within the home and we also looked at a wide range of records, including the care files of four people who used the service. This enabled us to determine if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed.

We also looked at the personnel records of four staff members, which helped us to establish the robustness of the recruitment practices and the level of training provided for the staff team. Other records we saw included a variety of policies and procedures, training records, medication records and quality monitoring systems.

We conducted a Short Observational focussed Inspection (SOFI) during our visit to Willow Lodge. This part of our methodology enables us to specifically observe a small number of people over short time frames.

The provider completed and submitted a Provider Information Return (PIR) within the time frames requested. A PIR 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 our inspection we reviewed all the information we held about the service, including notifications the provider had sent us about important things that had happened, such as accidents, deaths and safeguarding incidents. We also looked at the information we had received from other sources, such as the local authority and community professionals involved in the care and support of those who lived at the home.

Is the service safe?

Our findings

People we spoke with felt those who lived at Willow Lodge were safe. One relative commented, "[Name removed] is very safe here. They [the staff] look after him well. Some of the people who live here can be quite difficult, but the staff know how to handle them in a safe way."

Records we saw showed that a range of risk assessments were in place, which addressed areas such as moving and handling, falls, skin integrity and nutrition. However, these were not always linked to the plans of care and when tracking the care of two people with behaviours that challenged the service, we found there were some gaps in this process. For example, risk assessments had not been completed in relation to high risk behaviours. This meant that staff may not have all the necessary information to support them in a safe manner.

Another person was displaying distressed reactions on a regular basis; this placed them, staff and other residents at significant risk. The service had not implemented robust risk management plans to detail how staff should anticipate, monitor or intervene with such behaviours. However, staff we spoke with had a good understanding of this person's needs, although without clear plans of care and robust risk assessments continual management of the person's individual needs may not have been sustained.

Nutritional risk assessments were in place in all the care plans we viewed. These assessments were designed to identify those at risk of poor nutrition or de-hydration and included measures to help maintain people's nutritional status. These assessments had been reviewed on a monthly basis. However, risk assessment outcomes had not been cross referenced to the related nutritional care plan to ensure that management plans were in place. This would help to ensure that staff have all the information they need in one place to help them achieve good nutritional support.

The findings above constituted a breach of regulation 12 (1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at records relating to incidents of abuse within the home. We found that there had been a high number of incidents between people who used the service that had resulted in physical incidents, which was a concern. We found that there were some people who used the service with very complex needs. Risk assessments in relation to some of these people were not available to identify the potential risk or how risk would be managed. This meant that people who used the service were not always protected from abuse. We found that referrals had been made to the local safeguarding authority; however recording of safeguarding incidents was not robust.

This was a breach of Regulation 13 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found continuing concerns that the provider had not met the required standard in medication management and therefore people remained at risk. We looked at four people's care records associated

with medicines administration and viewed stocks of medicines within the home. An electronic medicine administration system was being used and the registered manager told us that the system was hindering safe medicine management, due to continued poor stock control and a lack of staff knowledge when recording the administration of medicines within the new system.

We found that the oversight of medicines management was poor. Significant omissions in medicine administration meant that people were not receiving their medicines as prescribed. For example, one person had not received their antipsychotic medicine on 10 occasions within 28 days; the same person had not received a medicine to help manage distressed reactions on 12 occasions within the same 28 day period. Another person had not received their antidepressant treatment on three occasions across 28 days.

A third person was prescribed a steroid cream and had not received this treatment for 14 consecutive days. Staff were unable to clarify why this treatment was prescribed and a care plan had not been formulated to ensure that the treatment was correctly administered. These omissions of prescribed medicines could have potentially had a serious detrimental impact on those people who missed their medications.

We judged that medicines management was unsafe. We were assured by the registered manager that safeguarding referrals would be made for all people who had not received their medicines as prescribed.

We checked stocks of medicines with the deputy manager. We found that the electronic recording device did not always correctly correspond with the actual numbers of medicines in stock. For example, five medicines showed variances in the amounts recorded when checked against the actual number of medicines held within the home. This meant that the current stock management system was not robust and meant that people were at risk of not receiving their medicines as prescribed.

We found that staff had incorrectly coded some medicine records, by recording that medicines were not required when the medicine was in fact prescribed on a regular basis. This meant that people's medicines were not received as prescribed.

Some people who used the service were prescribed medicines on an 'as required' basis. We found that where this was the case, there was a system in place for additional information for staff about when the 'as required' medicines should be offered. However this was not always adhered to. One person was prescribed a medicine for agitation; an 'as required' protocol was not in place to ensure they received their medicines when needed.

The registered manager told us that she did not think the new medicine system, which had been introduced was sufficient for Willow Lodge, because it was not flexible enough to allow for refusals of medication or people spitting their medicines out. She said, "The system doesn't adapt well enough for the amount of medication changes in this home."

We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because medicines were not well managed. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All medication records we viewed contained a photograph of the relevant person to help reduce the risk of identification errors. Important information such as any allergies the person had was also recorded. We found that medicines, including controlled drugs, were stored in a secure and appropriate manner.

Immediately following our inspection the provider and registered manager withdrew the electronic

medicine system and reverted to paper records, until a new pharmacy provider could be identified, who could introduce a more suitable system to ensure the safe management of medicines. The registered manager also submitted an action plan shortly after our visit, which highlighted action she had taken promptly, in order to address the medicine shortfalls identified at the time of our inspection.

We observed staff members transferring people and helping them to mobilise on several occasions. These manoeuvres were always conducted in a safe and competent manner, whilst good explanations were provided to the individual being assisted, with reassurance, encouragement and praise being offered throughout.

During the course of our inspection we looked at the personnel files of four staff members. We found that robust recruitment practices had been adopted by the home. References had been obtained and Disclosure and Barring Services [DBS] checks had been conducted before people started to work at Willow Lodge. DBS checks allow managers to establish if any prospective employees have a criminal record or if they have received any cautions, to enable employers to make a decision about appointing them.

Staff we spoke with talked us through their recruitment and induction processes. They felt that their recruitment and induction were thorough and they gave some good examples of subsequent training, which they had completed. These modules included health and safety, moving and handling, first aid, dementia awareness, safeguarding vulnerable people, mental health and first aid.

We asked staff about their understanding of safeguarding. Staff members were aware of the procedures to follow should they have concerns about the welfare of those who lived at the home and were confident to raise safe guarding concerns, should they need to do so. Accident and incident records were maintained appropriately in line with data protection guidelines and these events were escalated in accordance with the company's written reporting policy and procedure guidelines.

Records showed that all staff members had completed training in relation to fire safety awareness. Each person who used the service had a PEEP in place. A PEEP is a Personal Emergency Evacuation Plan. It is a bespoke plan for individuals who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time, in the event of any emergency, such as fire or flood. This assists emergency services to help people to vacate the premises in the safest and most effective way. An emergency grab bag was available in the reception area of the home, which contained essential items, should evacuation be necessary. The contents of this were checked each month, but would be replenished if used.

We saw that a wide range of environmental assessments had been conducted, within a risk management framework, in order to keep people safe and records showed that some internal checks were completed regularly in order to protect people from harm. Information was available for staff in relation to fire safety.

Records showed that systems and equipment within the home had been serviced in accordance with the manufacturers' recommendations. This helped to make sure they were fit for use and therefore promoted people's safety.

A business continuity plan had been developed, which outlined what action staff needed to take in the event of an emergency situation arising, such as gas leak, power failure, flood, fire, adverse weather conditions, bomb threat, terrorist attack, pandemic or utility disruption. This helped to ensure that people were protected from harm.

There was an infection control policy in place with good information for staff about the correct use of

Personal Protective Equipment [PPE]. We noted that Personal Protective Equipment and clinical waste receptacles were provided. We were told that there was ample PPE available and that this was easily accessible. Clinical waste was being disposed of in the correct manner.

During the course of this inspection we toured the premises and found that significant improvements had been made to the environment. The home was warm and comfortable throughout. Many areas had been decorated, upgraded and modernised. More suitable flooring had been installed in the lounge area and new furniture had been purchased, including profile beds. There were no unpleasant smells noted and the home was clean and hygienic throughout. However, several bedroom doors slammed shut and were in need of adjustment, in order to prevent entrapment injuries, one bedroom door did not fit properly into the door frame and the radiator cover in the corridor opposite bedroom 4 was not completely secure. There was no light bulb above the hand basin in one bedroom and no paper hand towels in the dispenser. The registered manager gave us assurances that these areas would be addressed without delay and very soon after our inspection she confirmed that this work had been completed.

One of the conservatories acted as a dining room. However, this area was in need of upgrading and modernising, as it did not promote a pleasant environment for people to dine in. The registered manager told us that plans were in place to dismantle this conservatory, because it was not suitable for the needs of those who lived at Willow Lodge. It is recommended that the conservatory be taken down and alternative arrangements be made to provide a more pleasant dining experience.

Is the service effective?

Our findings

Everyone we spoke with told us that they thought the food was of a good standard. One person said, "Yes, I like the food. It is nice." People felt there were enough staff on duty and that the staff team were competent to do their job.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to 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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The service had implemented mental capacity assessments. The registered manager told us how these needed to be developed to ensure that assessments were decision specific. We looked at four people's care records and found that consent to care and treatment had been considered.

We found that the registered manager had taken the correct steps to make DoLS applications, where appropriate and had notified us of all DoLS approvals. We viewed DoLS assessments for two people who lived at the home and found that a very high standard of detail had been recorded and restrictions in place were clearly outlined.

We observed people being offered choice and control during meal times and during medicine administration. Staff had a good understanding of the MCA and DoLS processes.

We noted that where people were unable to make specific decisions because they lacked the capacity to do so and where a legal representative had not been appointed, then discussions had been held between relevant parties to ensure that decisions were made in the individual's best interests.

A policy was in place at the home in relation to the MCA and Deprivation of Liberty Safeguards [DoLS], We saw that the majority of care files included consent to receive various aspects of care and support.

At our last inspection on 26 October 2015 and 6 November 2015 we found that the registered person had not ensured that the premises were properly maintained throughout. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions in relation to the premises were on-going.

During the course of this inspection we toured the premises and found that significant improvements had been made to the environment. Several areas of the home had been decorated, upgraded and modernised. More suitable flooring had been installed in the lounge area and new furniture had been purchased, including profile beds and specialised mattresses, which were safer and provided more comfort for those who lived at Willow Lodge. An improved nurse call system had also been installed. However, some areas could have done with painting, such as the woodwork in the corridors. The laundry department had been upgrade. Therefore, the breach of regulation 15 had been met.

New employees were issued with a good amount of information, which helped them to understand what was expected during their employment at Willow Lodge. An employee handbook, job descriptions relevant to specific roles, terms and conditions of employment and general social care codes of conduct were given to all new staff. Together these contained relevant information about important policies, such as disciplinary and grievance procedures, equal opportunities, effective communication and appraisals. This helped to ensure that new staff were supported to do the job for which they were employed.

Staff personnel records showed that new employees received a three months probationary period. This helped to ensure they were suitable for the position for which they had been appointed and that they wished to continue as a permanent employee.

Induction programmes for new staff members, covered a wide range of learning modules, such as privacy and dignity, discipline and grievance, complaints, independence, rights and choices, safeguarding and confidentiality. Those we saw were in general completed. However, areas of the induction record for one person, who was still in their probationary period, was signed off by their mentor, but not signed by the employee. We discussed this with the registered manager, who told us that the induction records are usually signed off at the end of the probationary period, but that she would implement a system whereby the records were signed, as topics were covered.

Records showed that employees received regular, structured supervision sessions and annual appraisals. This enabled staff to discuss their work performance and training needs with their managers and allowed them to highlight any areas of concern or difficulties experienced, so that any issues could be addressed promptly.

Staff also told us they felt supported by the management team. They said, "I have regular supervision. The manager is very approachable." "The manager is always responsive and approachable." And "My supervisions are positive and the manager listens to me."

Staff told us that they received effective training and they gave some good examples of learning modules, which they had completed. Records we saw supported this information. Certificates of training were retained on the personnel records we saw. These covered learning modules such as, emergency first aid, pressure care, continence care, moving and handling, challenging behaviour, health and safety, end of life care, dementia awareness, safeguarding, the Mental Capacity Act and Deprivation of Liberty Safeguards and infection control.

Comments we received from the staff members we spoke with included, "I had a good induction, I was shown around the home told about safety and was given a thorough handover about all of the resident's needs." "We are encouraged to undertake care qualifications." "I am happy with the training and feel that I am able to maintain and improve my professional skills." And "I have recently done some training about challenging behaviour, it was very good."

We observed staff undertake skilled and competent care interventions. People were safely assisted when mobilising and a good standard of communication was observed between care staff and people who lived at Willow Lodge.

The training matrix showed a good percentage of staff had completed modules, such as first aid at work, food hygiene, infection control, medicines management, information governance, safeguarding, fire safety, moving and handling, health and safety, basic life support, Mental Capacity Act and Deprivation of Liberty Safeguards, dementia awareness and equality and diversity. Evidence was available to show that mandatory training programmes were renewed at set intervals.

We observed the meal service at lunch time and saw that people were provided with a choice of two hot meals, as well as two sweet options. People appeared to enjoy the food served. We did not see staff offer extra portions when people had finished their meal. However snacks and drinks were provided between set meal times.

Staff assisted people to eat in the dining and lounge areas. Most staff supported people to maintain their dignity by sitting with them and using protective clothing when needed. However, we did observe one care assistant standing over two people assisting them to eat their lunch at the same time. This meant that the people involved were not receiving a person centred service.

Coloured melamine crockery and cutlery was provided for those who lived at Willow Lodge. This enabled people who lived with dementia to maintain more independence at meal times. We observed people to be engaged at the lunch time meal and orientated to the dining table. The registered manager explained that maintaining dining standards at the service was a challenge, due to the complex cognition needs of people who lived at the home; however, this was under continual review.

We spoke with the cook who demonstrated a good standard of knowledge regarding nutritional management for people who lived with dementia. The cook told us that they are provided with regular updates about peoples nutritional needs and we viewed written documents, which highlighted if people needed specialist diets or were at risk of weight loss.

We found that people were referred to external health care professionals in a timely manner. Care records showed that multi-disciplinary professional reviews were undertaken and partnership working was evident.

During the inspection we received positive feedback from an Independent Mental Capacity Advocate [IMCA] who was the Relevant Persons Representative [RPR] for one individual who lived at the home. They told us, "[Name removed] has settled really well here. The staff are very good at communicating with me. The manager always makes time to speak with me."

Is the service caring?

Our findings

Everyone we spoke with were satisfied with the care and support provided at Willow Lodge. One relative commented, "The staff try their best. Mum is well looked after here."

There were 19 people who lived at the home at the time of our inspection. We spoke with three of them and four relatives, who provided us with positive feedback about the level of service they received and the caring attitude of the staff team.

At the last inspection we found the registered person had not ensured that people were consistently treated with dignity and respect. Therefore, the registered manager had introduced a specific plan of care in relation to privacy and dignity. Although, these were found to be generic and a more person centred approach could have been adopted in relation to planning this area of care needs, we did find that the importance of respecting people's privacy and dignity was included within other specific plans of care, such as personal care and night care. Since this inspection the registered manager had circulated a staff questionnaire, in order to establish their understanding of respect.

During our inspection we observed people receiving support throughout the day. During our Short Observational focussed Inspection (SOFI) we saw that staff interacted with people in a pleasant and kind manner and approached them with dignity and respect. During the lunch time meal service we saw a kind intervention between a care worker and one of the people who lived at the home. The care worker acknowledged that the person was becoming restless and helped them feel calmer by talking to them about their past history. The care worker appeared to have a very good understanding of the person's life history, needs and preferences. Another care worker asked if one person was warm enough and went to get a blanket for them.

We saw another care worker settle one person who was distressed with a warm cup of tea, which she thoroughly enjoyed. These examples of positive interaction demonstrated that people's needs were anticipated well and that the staff team were fully aware of how to make people more comfortable.

A member of staff said to one person who lived at the home, "[Name removed] would you like to sit down love." This person said he would, so he was gently assisted to the chairs and was then offered a choice of where he would prefer to sit. The care worker then sat with him for a while having a chat. Other members of staff moved around the lounge having a chat with people about everyday things and their interests, which was pleasing to see.

We observed that people appeared comfortable and relaxed in their surroundings with their dignity being respected. Everyone looked well presented. We overheard staff members speaking with people in a respectful manner and saw them knocking on bedroom doors before entering. This helped to ensure privacy was promoted for those who lived at Willow Lodge.

During our tour of the premises we noted that within each bedroom a notice was displayed on the inside of

the door, which reflected a 'traffic light' system identifying certain levels of support needed by the occupants. This did not promote people's dignity, as anyone, such as fellow residents in shared rooms, none care staff, visitors, contractors or external professionals could easily view this information. We discussed this with the registered manager at the time of our inspection, who told us that staff members, particularly agency staff found the prompts useful. The registered manager has since told us that these notices have been removed, in order to promote people's dignity.

Staff were seen to approach people in a kind and respectful manner. They helped people to be as independent as possible and supported them to join in activities at the home. It was evident from our observations that staff knew people well. Good guidance was provided for the staff team, in relation to people's care and support and how to promote people's independence.

There was evidence available to show that people would be assisted to access the support of an advocate, should they wish to do so. An advocate is an independent person, who will help people to make specific decisions, which will be in their best interests. This demonstrated that people's best interests were considered and that they were supported to access services relevant to their needs.

Relatives we spoke with were very complimentary about the attitude and approach of staff members who were supporting those who lived with dementia. They (the relatives) described them (the staff) as, 'caring', 'kind' and 'patient'.

Is the service responsive?

Our findings

We asked people if they were involved in the planning of their care. Comments we received included: "I see it [the care plan] once a year"; "It's [care plan] in my room." One relative responded by saying, "Absolutely."

One relative told us, "I have never had to make a complaint. [Name removed]'s needs are generally met by the staff. The staff have a good attitude and really do their best." Another commented, "I have no cause to complain. [Name removed] gets excellent care and the staff are lovely with him." And a third said, "[Name removed]'s needs are met, but if I did have any concerns I would raise them with the manager."

We looked at the care files of four people who lived at Willow Lodge. They were, in general well written; person centred documents with clear guidance being provided for staff about the majority of people's needs and how these needs were to be best met. However, some aspects of people's care were not always incorporated into the plans of care.

Pathway tracking is a system we use to ensure people are receiving the care and support they need. We pathway tracked the care of two people who were known to display behaviours that challenged the service. We saw that there were a high number of incidents for both individuals, which had impacted on other people who lived at the home. The registered manager had rightly raised safeguarding alerts and attempted to involve other professionals in the care and support of these people. However, high risk behaviours were not fully described or risk assessed in the care plans. There was some limited information in plans of care for staff about strategies to support people in challenging circumstances, but these required more detail.

One person was at high risk of falling, their mobility care plan did not stipulate this risk or how the risk would be managed to prevent personal injury. Another person had been identified at risk of developing pressure sores; however their care plans did not reflect how the risk would be managed. This meant that systems in place to monitor and prevent risk were not robust.

We found that the care planning process did not always reflect people's needs and systems were not always in place to monitor and prevent risk. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care plans we viewed contained evidence that a pre-admission assessment had been carried out prior to a person being offered a place at the home. It was evident that information had been gathered from a variety of sources, which helped to develop the plans of care in a structured way. This helped the staff team to ensure they were able to provide the care and support required before people moved into Willow Lodge.

Whilst care planning was not reflective of behaviour management for the people that we pathway tracked, observations of care interactions throughout the inspection were positive. Staff understood the needs of people they cared for. We found that information throughout many care plans held a good standard of person centred detail. One person's care plan told a story about their current preferences, education, family connections and employment.

The care records we saw showed that those who lived at the home or their loved ones had, in been involved in planning their care and support. This was confirmed by people we spoke with. Plans of care had been reviewed regularly and any changes in needs had been recorded well. The care records of one person, who we pathway tracked showed that they had steadily lost weight over the previous year. However, a nutritional risk assessment was in place and clear person centred guidance was provided for staff, in relation to the management of this individual's nutritional status. We discussed this with the manager at length, who was responsive to the person's needs and records showed that external health care support had been sought. Records showed that a wide range of community professionals had been involved in the care and support of those who lived at the home. This helped to ensure people's health and social care needs were being appropriately met.

Evidence was available to show that the service worked effectively with external professionals, such as community health care workers and social workers. This helped to ensure that the health and social care needs of people were being appropriately met. Staff members who we spoke with were able to easily discuss the needs of those in their care and how these needs were to be best met.

On the day of our inspection we observed activities taking place, such as 'Colour me wild' and 'Keep fit'. People were given a choice of activity, but did not have to participate, if they preferred not to do so. We were told that external agencies visited to provide some of the activities. For example Cedar farm were providing 'Colour me wild' on the day of our inspection. We saw people receiving manicures and others just sitting and enjoying a chat with staff members. Records we saw confirmed that regular activities were provided for those who lived at Willow Lodge.

We spoke with one relative, who confirmed that his wife was taken to the family home regularly by the registered manager and that she took them out for coffee from time to time. This enabled good integration with the local community.

Staff presence in communal lounge areas was noticed throughout our inspection. by staff throughout our inspection and we saw small pockets of activities being provided. We noted that people were supported to maintain contact with family and friends and we did observe visitors coming and going without any restrictions.

People we spoke with were confident in making a complaint, if they needed to do so, or they would ask a relative to support them in doing so. A complaints policy was in place at the home. This included specific time frames to expect during an investigation and included external agencies that may be contacted, if it was necessary. A system was in place for recording any complaints received.

Is the service well-led?

Our findings

People we spoke with felt the home was being well-managed. One relative told us, "I can go to the manager at any time and discuss anything." Another commented, "The manager goes over and above to please people. She will do anything to make them [the residents] happy." And a third said, "[Name removed – staff member] is excellent and [Name removed – staff member] is wonderful."

At our last inspection on 26 October 2015 and 6 November 2015 we found the registered provider had not ensured systems and processes had been established to effectively assess, monitor and mitigate risks relating to the health, safety and welfare of service users. Therefore, this area was in need of improvement, so that the service could be sufficiently monitored under a continuous assessment process and any improvements needed could be identified and addressed in a timely fashion. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement about this. The provider sent us their action plan, which showed that actions would be completed by 15 April 2016.

At this inspection we found that quality monitoring systems had been implemented. However, these did not include action plans and they were not always accurate. For example, the medication audits for September and October 2016 showed that there were no areas of non-compliance in relation to the management of medicines. We identified several areas of significant concern in this area, which had not been picked up through the internal auditing system. Therefore, this constituted as a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This was a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A Statement of Purpose [SoP] was in place at the home. This had been recently reviewed, so that current information was provided for any interested parties. It included a clear description of Willow Lodge, the aims and objectives of the service, the philosophy of the home and the core values of care.

A wide range of policies and procedures were available at the home. These included areas, such as infection control, fire safety, confidentiality, safeguarding vulnerable adults, health and safety and the Mental Capacity Act and Deprivation of Liberty Safeguards. However, it is recommended that these are reviewed and updated, as needed, as many had not been reviewed for several years. This would help to ensure that current information was provided for the staff team and any other interested parties.

A system was in place for obtaining feedback about the quality of service provided. The responses to surveys were produced as an overall result and these were displayed within the home, so that any interested party could access the results.

Records showed that management meetings were held between the provider and the registered manager, during which time future plans, actions and outcomes were discussed. Staff meetings were also held. This

enabled those who worked at the home to discuss topics of interest in an open forum and to raise any issues or areas of good practice with colleagues. It was evident that any relatives were able to visit their loved ones, when they wished to do so and people we spoke with confirmed that the registered manager of the home was accessible to discuss any concerns they may have, so that issues could be dealt with promptly.

Staff members we spoke with told us that they felt well supported and were happy working at Willow Lodge. The registered manager had been in post for several years and following this inspection she submitted an action plan, showing how the shortfalls identified were to be addressed, in order to meet the standard of service required. The manager of the home was aware of the need to notify the Care Quality Commission of certain events, such as allegations of abuse, unexpected deaths and incidents resulting in serious injury.

The company had been accredited with a gold external quality award, which involved an independent professional organisation periodically auditing the business, to check if acceptable standards were being maintained.

We received feedback from a group GP's practice, which stated: 'The GPs have found the service and care provided to be really good since the takeover of Willow Lodge a few years ago. The Nursing Staff are found to be of high quality and are very caring. The staff are good at identifying patients in need of end of life care and of managing resident's needs. The Nursing Home is well managed. Improvements have been made to the home resulting in a much brighter and dementia friendly environment. On visiting the Nursing Home the GPs have also noted that the food provided to residents looks to be of high quality. There are good channels of communication between Willow Lodge and the Surgery. Overall the GPs describe the care provided to residents of Willow Lodge as extremely good. They have confidence in the care provided and have no cause for concern.'

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	We found that the care planning process did not always reflect people's needs and systems were not always in place to monitor and prevent risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	We found that care and treatment was not always provided in a safe way for service users, because risks to their health and safety had not always been assessed and the provider had not done all that was reasonably practicable to mitigate such risks.

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	We found that quality monitoring systems did not always identify shortfalls recognised by the inspection team and therefore they were not consistently effective, particularly around medication management.