Willett Lodge Care Home Ltd

Willett Lodge

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
Willett Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The care home provides accommodation and nursing care for up to 20 people in one adapted building. The home provides support for people living with a range of healthcare, mobility and sensory needs, including people living with dementia. There were 18 people living at the home at the time of our inspection.

People's experience of using this service and what we found
People were not always protected from avoidable harm because risks to people's health and wellbeing were not consistently managed. Processes were not in place to ensure care plans and risk assessments were reviewed and updated following specific risk incidents or events. Care plans did not contain detailed and person-centred information to accurately reflect the needs of people and mitigate identified and potential risks.

There was no adequate process for ensuring that care recommended by specialist healthcare professionals was implemented. People's risk management plans lacked important detail to guide staff on how to keep people safe or manage specific health conditions.

Staff were recruited in accordance with the providers policy, although recruitment processes for agency staff were not always robust enough ensure that agency staff employed at short notice were inducted sufficiently, or had the skills, training and competence to provide safe care.

We observed a task focussed culture of the service which meant that care was not consistently person centred and did not always promote good outcomes for people. Staffing levels were not always sufficient in meeting people's emotional or psychological needs in a person-centred way, and staff did not always have time to provide structured, meaningful activities for people to engage in.

People were supported to have maximum 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 supported this practice.

People were cared for by staff who were kind and compassionate. People received support from a consistent team of staff who knew them well. Relatives told us they thought their loved ones were safe and there were enough staff to support them and meet their needs.

Staff had received training in infection prevention and control (IPC) and IPC practice within the home was aligned with current government guidance.

Rating at last inspection

The last rating for this service was Good (published 27 March 2018).

Why we inspected
The inspection was prompted in part by notification of a specific incident, where concerns had been raised regarding the security of the home. This incident is subject to a police investigation. The information CQC received about the incident identified concerns about the assessment and management of risks, people's safety and neglect. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. This inspection examined those risks.

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.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from 'Good' to '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 Willett Lodge on our website at www.cqc.org.uk.

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.

We have identified breaches in relation to providing safe care and treatment, recruitment and the overall governance of the service at this inspection.

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
After the inspection we contacted the provider about some of the urgent concerns found during inspection. The provider sent us assurances and evidence that informed us of the immediate actions they had taken to address these concerns.
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. 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.

Willett Lodge

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 Care Act 2014.

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
Willett Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. 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. This means that they 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
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

Before the inspection we reviewed the information we held about the service. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We used all this information to plan our inspection.

During the inspection
We spoke with two people who used the service and one relative about their experience of the care provided. We spoke with six members of staff including the provider, registered manager, care workers, housekeeping staff and the chef. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed a range of records. This included five people's care records and multiple medication records. We looked at three staff files in relation to recruitment and supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We spoke to three relatives and continued to seek clarification from the provider to validate evidence found. We looked at a range of information including training data, infection prevention and control documents, minutes of meetings and quality assurance records. We requested feedback from two professionals who regularly visit the service.

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 Good. At this inspection this key question has now deteriorated to 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; Learning lessons when things go wrong

● People's risks were not always assessed, monitored or managed in a way that consistently kept them safe. Risk assessments and care plans did not contain detailed information about people's needs. For example, one person's risk assessment stated they experienced anxiety, restlessness and episodes of confusion, although there was no person-centred guidance for staff to support them in a consistent way that would reduce their distress. Another person was assessed as at risk of causing harm to others, their care plan did not provide detailed information and guidance on how to support them appropriately to mitigate these risks should they present with behaviour that challenged. This placed people at potential risk of harm.

● Prior to this inspection we received information of concern about the homes security which had placed people at risk. One person was able to leave the home without staff knowledge. This had also occurred on a previous occasion. Although the provider had taken action to improve the security of the home, the person's risk assessment and management plan had not been updated and did not provide staff with guidance in how to support them to remain safe. The management plan in place was not followed, nor did it reflect the previous known risks about the persons behaviour. This not only placed the person at risk but demonstrated how lessons resulting from previous incidents had not been learnt to promote safe and consistent support for people.

● Agency staff employed at short notice were expected to receive an induction at the start of their first shift. They would be shown the fire evacuation procedure, receive information about people and be given log in details so they could access the services computerised records. The electronic records contained important information about people's needs, risks, and tasks to be completed throughout the shift. The agency staff member working their first shift, had not received an induction or access to people's electronic care records. This potentially posed significant risk to people from staff who were not aware of their assessed risks and needs.

● The provider had not always ensured that changes to peoples care were recorded to reflect their current needs. For example, a person had fallen and sustained an injury. On return from hospital their care plan guided staff on how to support with their mobility and what equipment was required. The care plan indicated that a stand aid should be used to support the person standing until a clinical review of their needs had taken place. The team had decided to hoist the person to maintain their safety until reviewed by a physiotherapist. The persons care plan and risk assessment had not been updated to reflect this change, therefore guidance for staff to ensure the person was supported to move and reposition safely was not current and up to date. This had potential to have further impact on the person's safety or recovery should staff adhere to the previous care plan.

● Two people had pressure wounds, there were no care plans in place detailing how these wounds should be cared for. Records relating to the care of these wounds was documented across two different systems

and showed inconsistencies regarding the care one person had received. A significant deterioration in one person's wound was noted over three days. It was not clear what care that person had received. Staff said that changes to this person's care were implemented after advice was sought from a specialist healthcare professional. However, there was no evidence to confirm what the advice had been; therefore people could not be assured they were receiving safe care and treatment or staff were implementing best practice guidance for wound care.

● Another person assessed as high risk of falls had fallen on four occasions over two months; on three of these occasions the person banged their head. There was no evidence to show that increased monitoring had been consistently implemented following the falls where head injuries were sustained. Specific observation tools to monitor people after a head injury were not always used. Specialist advice had not been sought as to how the risk of falls could be managed more effectively, this resulted in another professional referring to the local authority Safeguarding team. The provider did not have guidance in place for when people fell or how to monitor them if they banged their head, this put people at risk of potential harm.

We found that people had not always been kept safe from avoidable harm. Care plans and risk management plans were not always updated to reflect changes in risk or contained enough detail about people's needs. Advice from health professionals was not always acted upon or documented to promote consistent care. This placed people at risk of potential harm. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to concerns immediately during and after the inspection. They provided assurances around access and security risks. We were given assurances and provided with evidence that following our inspection care plans were updated for wound care, falls and guidance for staff as to how to support people after a fall.

● People who were at risk of choking had a choking risk assessment and had been referred to the Speech and Language Team (SALT) for advice on how to keep them safe. Care plans had guidance for staff when supporting people with their meals. Kitchen staff were aware of who required a modified diet. We observed staff supporting people at risk of choking with their meals safely.

● Relatives felt their loved ones were safe. One relative said, "Yes very safe, from what [person] tells me, they're very happy. [Person] says the staff are very caring and very friendly." Another relative told us their loved one's care was "100 percent. It's nice because I know they're in a safe place and a lot less stressful for me."

Staffing and recruitment

● Recruitment processes were not always safe. An agency staff member had been employed via an agency where the provider had not exercised due diligence prior to using the agency. This meant they could not be assured that the staff member employed to work at the care home was safe, and had the relevant skills, training or competence to meet people's complex needs.

Staff were not always recruited safely. This placed people at potential risk of harm. This was a breach of regulation 19 (fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider subsequently confirmed they are no longer using this agency. They told us they would require the agencies they use to provide a staff profile containing relevant training and disclosure and barring service (DBS) status prior to that person commencing work at the home. The providers recruitment policy would be updated to include more robust recruitment measures.

● Staff told us they felt there were enough staff to meet people's needs, though our observations showed this did not always include people's emotional or social needs. Staff rosters showed the assessed number of staff were working each shift. One staff member told us, "It goes through stages, now, there are more people that require support from two carers. I think four staff on shift is a good amount". One relative told us there was a "high level of staffing here, there always seems to be a lot of staff."
● Staff had received mandatory training which they felt enabled them to provide safe care. Nurses had completed specialist training to support people with specific nursing needs. A relative told us they felt, "the staff here are skilled and have good knowledge of dementia".

Preventing and controlling infection
● We were somewhat assured the provider was preventing visitors from catching and spreading infections. When visiting professionals attended the service, they were not always asked to complete a lateral flow device test (LFD) for Covid-19 or provide evidence that one had been completed. Therefore, the provider could not assure themselves of the visitors Covid-19 status before they entered the home. This was raised with the registered manager who stated their visiting policy would be amended to reflect current guidance. The provider had processes in place to ensure that visits from relatives were carried out safely. When visitors had declined to complete a lateral flow test, a risk assessment had been completed.
● We were somewhat assured that the provider was meeting shielding and social distancing rules. Although the home had remained without any positive cases of COVID-19 throughout the pandemic, furniture throughout the home had not been spaced in accordance with social distancing guidance and people did not have care plans to guide staff as to how this would be managed. This meant the provider could not be fully assured all was being done to reduce the risk of potential transmission.
● We were somewhat assured that the provider's infection prevention and control policy was up to date. Covid-19 policies had not been updated with the most recent changes in government guidance.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
We have signposted the provider to resources to develop their approach.

Systems and processes to safeguard people from the risk of abuse
● There were systems and processes in place to safeguard people from the risk of abuse.
Safeguarding training was completed by new staff as part of their induction. There was a system to monitor and ensure staff undertook refresher training. Staff had an awareness of signs indicating a person might be vulnerable to abuse and knew how to identify them.
● Staff understood their responsibilities for reporting concerns. A staff member told us they would report any concerns they had immediately to the registered nurse or manager.
● The registered manager understood their role and responsibilities in relation to Safeguarding. They had notified CQC of incidents of alleged abuse for which the appropriate actions had been taken. This included referrals to the local authority and completion of investigations into how and why incidents had occurred, and any actions resulting from what was found.

Using medicines safely

● Medicines were managed safely. Staff had completed medicines training and had been assessed as competent before giving people medicines.
● There were processes in place to ensure the safe storage, disposal and administration of medicines. Stocks of medicines were ordered and monitored effectively. Medicines audits were completed via the electronic records system. Any omissions or errors were identified through this process and acted upon to resolve.
● People who were prescribed medicines to be given at a specific time had been given them correctly. Consideration was given to how people's medicines may affect them. For example, one person was prescribed medicine for a health condition which affected their appetite. This person's weight was being monitored weekly and they received fortified meals to increase their calorie intake.
● We observed staff giving medicine with care, compassion and consideration to people's needs. One person who was unable to take their medicine from a pot was supported to use a spoon instead, therefore ensuring they received this in a dignified way.

Requires Improvement

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 the last inspection this key question was rated as Good. At this inspection this key question has now 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.

- Quality processes and systems in place did not always identify risks relating to the health, safety and welfare of people. Risks to people had not always been fully assessed, monitored or reviewed following a specific risk incident or when their needs changed.
- Quality assurance processes did not always provide effective oversight of the running of the service. Monthly quality reports collated information, though this did not always identify themes and trends which could be used to improve the quality of people's care. The frequency of falls for one person had reduced following changes to their individual care plan. However information collated and recorded monthly by the registered manager which included the frequency, time and location of when all falls had occurred, not been analysed to identify themes from which actions to help try and reduce falls throughout the home could be identified.
- The providers systems and processes had failed to identify shortfalls in practice relating to falls management, wound care and recruitment. There were no quality assurance processes for the provider to assure themselves that staff were implementing health professional guidance. Health professionals told us that when advice had been given, this was not always adhered to. Recruitment processes were not robust enough to ensure staff working at the home had the appropriate pre employment checks completed or the right knowledge, skills and qualifications to provide safe care.
- The registered manager could not be assured that people's care records reflected their ongoing needs and staff were meeting these appropriately. Records did not provide enough detailed information and guidance on how to support people appropriately and mitigate identified risk. When incidents had occurred risk assessments were not always updated to reflect current or previously known risk and there were no assurance systems in place to monitor the quality and standard of clinical documentation.

The provider had not ensured there were adequate systems to assess, monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people, and the suitability of staff employed at the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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

● People did not always receive person centred care in a culture that was inclusive and empowering to achieve good outcomes. We observed the culture of the home to be task focussed, with limited emphasis on providing regular meaningful activity to engage people, provide stimulation and promote emotional wellbeing. One staff member told us, "We're meant to be putting together an activities list, but we haven't got around to it. Sometimes a person who works here does extra and does activities, three or four times a week, but it doesn't always happen." Review of the staff rota confirmed time allocated for activities was three times each week. We observed a lack of meaningful activity throughout the day to ensure social and emotional needs were considered. This was raised with the registered manager who informed us that they are currently working on the development of a structured activity programme.
● The registered manager was keen to promote a person-centred culture and both they and the staff had in-depth knowledge about people's needs. The registered manager understood how people's needs should be met and what their expectations were of staff, however, this did not always match what we observed. For example, people were not always treated with dignity. While people were eating their lunch, we observed staff members talking across people while they were having their meal. There was no dining room or the opportunity for people to sit at tables to provide a positive mealtime experience, or a change of surroundings. One person we observed sat in the same armchair for several hours. After the inspection this was raised with the provider, who said they will consider how the environment is equipped to meet peoples changing needs and preferences.
● The registered manager was aware of their responsibilities under the Duty of Candour and had acted accordingly when required. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guideline's providers must follow if things go wrong with care and treatment.

The manager provided leadership for the team and staff understood their roles and responsibilities
● Staff had one to one supervision and had opportunities to discuss their learning and development needs. Staff told us the manager was supportive both personally and professionally and offered valuable feedback. Registered nurses had areas of clinical care for which they were responsible which was overseen by the deputy manager. Staff felt valued and part of a team. One staff member said, "I think we're all good at teamwork, especially during the lockdown, we all pulled together."
● The registered manager felt supported and reported a good relationship with the provider. They had plans for the continued development and improvement of the service and were engaged and responsive during and after the inspection.
● The registered manager understood their legal duties and sent notifications to CQC as required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff and relatives said the registered manager was approachable and communication was consistent and effective. One relative told us, "[manager] makes themself available at all times, I value their ability to communicate, the communication here is beyond good."
● Staff said they felt able to make suggestions to improve the service and running of the home. One staff member told us they felt they "would be listened to if they had any suggestions, but that changes might not happen straight away."
● Relatives were provided with a monthly newsletter and invited to give feedback about any changes being made or thoughts about the service. Relatives said they were kept up to date with the Covid-19 status in the home. One relative told us, "[manager] seems very open and honest. I think they have managed the pandemic really well."
● Staff stated that the registered manager requested feedback to identify ways they could improve. One staff member said, "[manager] is really good, they did a survey to ask staff what they could do better, I really like it here and the staff too."

Working in partnership with others

● The service worked in partnership with other agencies. Staff were aware of the importance of working with other agencies and sought their input and advice.

● The registered manager and nurses worked professionally with external agencies such as the local authority, GP practice and community matrons. People had access to a range of health care professionals. This enabled people's health needs to be assessed so they received the appropriate support to meet their ongoing 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
Treatment of disease, disorder or injury	The provider had failed to ensure there was adequate assessment of risks to the health and safety of service users receiving the care or treatment, nor had the provider ensured they were doing all that is reasonably practicable to mitigate any such risks.

The enforcement action we took:

Condition imposed on the providers registration.

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 had failed to ensure that systems or processes were established and operating effectively to ensure they could assess, monitor and improve the quality and safety of their service.

The enforcement action we took:

Condition imposed on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Treatment of disease, disorder or injury	The provider had failed to ensure that persons employed for the purposes of carrying on a regulated activity were of good character and had the qualifications, competence, skills and experience which are necessary for the work to be performed by them.

The enforcement action we took:

Condition imposed on the providers registration.