The Willows Residential Care Home Limited

The Willows

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Willows provides accommodation with personal care for up to 32 older people, including people living with dementia. It does not provide nursing care. Accommodation is provided in one adapted building. During our inspection visit 22 people lived at the home.

People's experience of using this service and what we found
People told us they felt safe but did not always receive safe care. Risks associated with people's care were identified, but care records were not always clear about how those risks needed to be managed to demonstrate consistent and safe practice. Infection prevention and control practices continued to require improvement although some areas had been addressed following the last inspection. Action to improve the fire safety in the home was ongoing to enable the home to be fire safe.

Sufficient numbers of staff were on duty. Staff training records were not accurate which meant the provider was not able to demonstrate staff had completed all of the training required to support them in providing safe care. People at the home living with dementia were not able to share detailed information of their experiences of care. Relatives felt people's needs were met but spoke of some areas where improvements could be made. People's care plans did not always provide sufficient detail to demonstrate how person-centred care was planned and provided. Medicine management remained in need of improvement to ensure people's healthcare needs were managed effectively.

A new manager had been registered with the service since the last inspection. Governance systems, management and provider oversight, continued to be inadequate due to the number of improvements still required. Systems and processes designed to identify areas of improvement continued to be ineffective. The conditions we had placed on the provider's registration following the last inspection had not been met. Audits and checks had not identified the concerns we found. This demonstrated lessons had not been learnt since our last inspection. The management of individual and environmental risks continued to require improvement.

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

Rating at last inspection (and update)
The last rating for this service was Inadequate (published 13 July 2021) and there were multiple breaches of the regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

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

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

We undertook this focused inspection to check they had followed their action plan from the last focused inspection and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well Led which contain those requirements. The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has improved from Inadequate 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 The Willows 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 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 continued breaches in relation to risks associated with people's care, and management oversight of the service. The provider had not ensured systems and processes in place to monitor the quality and safety of the service were always effective to continually drive improvement. The conditions imposed on the providers registration at our previous inspection have therefore remained in place.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Requires Improvement

Is the service well-led?

The service was not well led.

Inadequate

The Willows

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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 focussed inspection was carried out by three inspectors and an Expert by Experience. On 06 December 2021, two inspectors and the Expert by Experience visited the home. The Expert by Experience spoke with people about their experiences of the care and support provided. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Another inspector spoke with relatives via the telephone to gather feedback on their experience of the service.

Service and service type
The Willows 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

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return 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.

During the inspection
We spoke with four people who used the service and eight relatives/visitors about their experience of the care provided. Due to people living with dementia, most people were unable to talk with us in detail about the care they received, or the quality of the service provided. Therefore, we used other methods to understand what it was like to live at The Willows. This included observing how staff supported people to help us understand people's experiences of living at the home. We spoke with seven members of staff including the registered manager, the deputy manager, the chef, and the provider of the service.

We reviewed a range of records. This included three people's care records, and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records related to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider and registered manager to validate evidence found. We looked at a variety of records the provider had shared with us in relation to quality assurance and risk management.

Requires Improvement

Is the service safe?

Our findings

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

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

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

- Risks continued not to be identified, monitored and managed effectively.
- The home was not fire safe. Whilst the provider had attempted to improve the safety of fire doors within the home, actions taken were ongoing. Fire doors continued to need works completed to minimise risks of fire spreading. The provider shared immediate actions to further progress this following our inspection visit.
- Hot pipes were not protected, and people had access to hot surfaces, chemicals and work tools. This placed them at potential risk of harm such as burns to their skin caused by the hot pipes. Following our visit, the provider told us about actions taken to improve safety.
- There continued to be nutritional risks not managed. One person at risk of choking did not have clear records about the use of a thickening agent to be added to their drink. There was no choking risk assessment or instructions for staff on how to respond to a choking incident to ensure a consistent and safe approach. However, staff had some knowledge of what to do in the event of a choking emergency. The provider updated the person's records following our visit.

Systems and processes to safeguard people from the risk of abuse
- Where serious incidents had occurred within the home, these had not been consistently reported to CQC as required. This is required to provide assurance risks to people's health and safety had been managed to keep people safe. This remains an outstanding issue from the previous inspection.
- Staff were aware of their responsibility to safeguard people from harm and report incidents of concern to management. However, records completed following incidents did not consistently demonstrate changes in practice to show lessons had been learned to prevent any ongoing risks of harm.

Using medicines safely
- Processes to support safe medicine practice continued to need improvement.
- One person did not have their prescribed pain relief medicine available to them for two weeks. Their medicine records showed they were regularly taking the medicine until it had run out to relieve their pain. This was addressed following our inspection visit.

● Medicines continued not to be stored safely. A medicine cabinet containing prescribed creams had been left open and was accessible to people. A medicines trolley was also left open and unattended for a few minutes in a communal area. There was a risk people living with dementia may ingest medicines accessible to them. Action has subsequently been taken by the provider to address these issues.
● One person was prescribed medicine 'as required' to manage their levels of anxiety. Guidance available to inform staff when they should give the medicine was not personalised or detailed. There were no instructions for staff to record why it had been given to enable any triggers to the person's anxiety to be identified and ensure this was managed effectively. There was a risk the person may be given too much of the medicine which could cause them to be sedated when this was not necessary.
● Records did not show that topical creams and other prescribed items such as shampoo were used as prescribed. One staff member told us, "Every time they (staff) apply creams, they should record on care control (electronic care planning system)….sometimes they forget." The provider has subsequently advised us of actions taken to ensure this information is recorded.

Preventing and controlling infection
● We were not assured that the provider was admitting people safely to the service. The vaccination status of a person admitted to the home shortly before our visit had not been checked (this has been subsequently completed). People's temperatures were not recorded consistently to identify if the person may be unwell.
● We were somewhat assured that the provider was accessing testing for people using the service and staff. One person admitted from the community into the home had not been tested on the day of their admission to check if they had a COVID-19 infection. Lateral flow tests (LFT's) were not taking place daily until the polymerase chain reaction (PCR) test result was provided.
● We were somewhat assured the provider's infection prevention and control policy was up to date in accordance with current guidance. Links to guidance were available to staff but this was not always followed. For example, evidence of BAME (Black, Asian and minority ethnic) risk assessments were not seen to demonstrate risks had been assessed and actions taken to protect them.
● We were somewhat assured the provider was making sure infection outbreaks were effectively prevented and managed. Staff practice in relation to infection, prevention and control, had improved but checks in relation to the movement of temporary staff working at the home had not always taken place. The provider was not able to demonstrate staff worked only in one care setting to minimise the risk of the spread of infection.
● We were somewhat assured the provider was promoting safety through the layout and hygiene practices of the premises. The home was clean and there were cleaning schedules detailing cleaning completed for all areas of the home. Some people's personal toiletries and creams were located in other people's bedrooms which created a risk of cross contamination.
● We were somewhat assured the provider was preventing visitors from catching and spreading infections. Arrangements were in place to check visitors to the home had completed appropriate testing and some checks were made to ensure they were safe to enter the home. Sanitising gel dispensers located within the entrance to the home were not working correctly to enable visitors to sanitise their hands to minimise risks of the spread of infection.

We found evidence of risks related to people's health, safety and wellbeing. These included continued risks related to medicine management and preventing and controlling infection. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured the provider was meeting shielding and social distancing rules. Two lounges were in use to enable people to socially distance in communal areas. No one was in self isolation during our visit. Staff

had staggered breaks in the staff room or garden.
● We were assured the provider was using PPE effectively and safely. Staff wore personal protective equipment in line with current guidance and people confirmed staff wore PPE when supporting them.

The provider was facilitating visits for people living in the home in accordance with current guidance. Individual visitor plans were not in place, but arrangements were in place to enable visitors to the home and for people to maintain contact with relatives and friends. Whilst visits were accommodated in a "pod" near the entrance, other locations had not been explored to support flexibility and privacy when visits took place.

Care homes (Vaccinations as Condition of Deployment)
From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. We found the service had effective measures in place to make sure this requirement was being met.

Staffing and recruitment

At our last inspection the provider had failed to ensure there were sufficient numbers of staff with the skills, knowledge and experience to meet people's needs safely. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● People told us they felt safe but acknowledged differing approaches of temporary staff. One told us, "Oh yes (felt safe), new ones (staff) take a bit of getting used to."
● Checks to ensure temporary staff were safe to work at the home remained insufficient. The registered manager spoke of challenges obtaining information when temporary staff were organised at short notice. One staff member explained how they supervised temporary staff who they considered were not competent in the safe moving and handling of people.
● On the day of our inspection visit there were enough staff available to support people's needs. Staff spoke of there being sufficient staff available with exceptions of sometimes at night when attempting to fill gaps in the rota at short notice.
● Permanent staff had been recruited safely.
● Relatives felt there were sufficient numbers of staff available to support people. One told us, "Always seems enough staff on duty, they do seem a bit rushed at times, but people are looked after."

Learning lessons when things go wrong
● Whilst we acknowledge the challenges the provider has faced over the last twelve months, our inspection findings demonstrated audits remained ineffective. The provider had not learned lessons to ensure the overall quality and safety of the service sufficiently improved.
● Staff had completed accidents and incident records. However, the information recorded was limited and did not provide a clear overview of the circumstances surrounding the incident and the actions taken. Some had not been notified to CQC as required.

Inadequate

Is the service well-led?

Our findings

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

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

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

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

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

● This is the third time the provider has been in breach of Regulation 17. The provider had failed to submit monthly reports as required to demonstrate compliance with the conditions we had placed on their registration following the last inspection. Reports that had been submitted retrospectively had failed to provide assurance audits had been completed effectively.
● Lessons had not been learned. Systems and processes to assess and monitor the safety and quality of the service remained ineffective. This demonstrated the provider was unable to make and sustain improvements to benefit people. We found a system was not in place to effectively monitor, analyse and report accidents and incidents. The provider had also failed to meet their legal responsibility to consistently report serious incidents to CQC, to protect people from potential abuse or harm.
● Audits and environmental checks failed to identify and act upon risks we had found. This included burns from hot pipes and the unsafe management of medicines which placed people at risk of harm.
● The provider failed to ensure staff always followed procedures within the home to keep people safe. For example, we saw fire doors were wedged open all day presenting a fire risk, an unattended medication trolley was left open and a person had been admitted to the home without the required infection prevention and control checks taking place.
● Monitoring systems remained inadequate and had failed to identify one person did not have any care plans to instruct staff how to meet their needs (this was addressed during the inspection visit). In addition, systems had not identified people's weights were not being monitored effectively or that a person had not received prescribed food supplements as required to maintain the person's health and wellbeing.

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

(Regulated Activities)

● Managers used an electronic care plan system to monitor care delivery and any shortfalls. However, we found there were challenges in staff extracting information from the system to ensure they could meet people's needs safely. One staff member commented, "It takes a long time to access the information you want, it's a nightmare." The provider advised of ongoing training to address this.
● Relatives told us the management of the home had recently improved and people said they liked living at the home. One person commented, "The carers are nice." A relative told us, "I am very happy with the current care being provided to [Name]. We have had a few issues, but it's been better over the last few months."
● Staff told us they felt supported by management staff. One staff member said, "If we need anything, she (the registered manager) will try her best to get that sorted."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others
● The provider understood the need to be open and honest when things went wrong. However, our inspection findings and the continued breaches of the regulations confirmed sufficient action had not always been taken to make and sustain the required improvements.
● The provider worked with the health and social care professionals involved in people's care so they could support people's physical health and wellbeing.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● At the time of our inspection there were limited opportunities for people and relatives to provide feedback about the service provided. One relative told us, "No opportunity to share views - never been to a meeting with them."
● The home had a registered manager as required by the regulations. The registered manager felt supported by the provider.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured risks associated with people's care, and the environment were a;waus identified, assessed and mitigated. Regulation 12 (1) (2)

The enforcement action we took:

Continued imposed conditions on the providers registration.

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

The enforcement action we took:

Continued imposed conditions on the providers registration.