Willows Lodge Limited

Willows Lodge Care Home

Inspection report

82-84 Calcutta Road
Tilbury
Essex
RM18 7QJ

Date of inspection visit:
12 January 2016
13 January 2016
19 January 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Willows Lodge Care Home provides accommodation, personal care and nursing care for up to 62 older people, older people living with dementia and older people who require nursing and palliative care. The service consists of three units: Poppy Unit for people living with dementia, Buttercup Unit for people who require nursing and palliative care and Rose Unit for people who require residential care.

The inspection was completed on 12 January 2016, 13 January 2016 and 19 January 2016. There were 55 people living at the service when we inspected.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

A registered manager was in post. 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 in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Arrangements were in place to inform the provider and registered manager of what was going on in the service. Although these were in place, they were not as effective as they should be and there was a lack of provider and managerial oversight of the service as a whole, as areas of concern were identified. Checks were not effective to monitor and ensure pressure mattresses were set at the correct setting each day. Records were not properly maintained, for example, in relation to staff supervision, food and fluid monitoring and end of life care. Systems in place to identify and monitor the safety and quality of the service were inadequate.

Although staff had a good understanding of safeguarding procedures, robust arrangements were not in

place to ensure that people using the service were protected from abuse. Risks were not appropriately managed or mitigated so as to ensure people's safety and wellbeing.

Although there was a complaints system in place, management arrangements to investigate complaints thoroughly and to evidence outcomes were inconsistent.

The deployment of staff, particularly on Poppy Unit and Buttercup Unit was not always appropriate to meet the needs of people who used the service and required reviewing so as to ensure people's care and support needs were met. Staff did not always have enough time to spend with people to meet their needs.

The implementation of staff training was not as effective as it should be so as to ensure that staff knew how to apply their training and provide safe and effective care to the people they supported. Some staff did not demonstrate an understanding of how to support people living with dementia and how this affected people in their daily lives and how to support people who required end of life care. Though staff told us that they felt supported by the registered manager, staff had not received a thorough induction or received regular formal supervision.

People's comments were variable about the care and support provided. The majority of interactions by staff were routine and task orientated and we could not be assured that people who remained in their bedroom received appropriate care to meet their needs. Some aspects of care practices required improvements. These related to assisting people to eat and drink, communication with people living at the service and care and support to be less routine and task focused.

The dining experience for people was variable and not always appropriate to meet people's individual nutritional needs. Consideration by staff was not well-thought-out to ensure that eating and drinking was an important part of people's daily life and a positive experience.

Appropriate assessments had been carried out where people living at the service were not able to make decisions for themselves and to help ensure their rights were protected.

Appropriate recruitment checks were in place which helped to protect people and ensure staff were suitable to work at the service. The management of medicines within the service ensured people received their medication as they should. Suitable arrangements were in place to ensure that the service was clean, hygienic and free from offensive odours.

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

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

The service was not safe.

People were not protected or safeguarded from abuse as robust procedures were not being followed so as to ensure their safety.

Risks were not appropriately managed or mitigated so as to ensure people's safety and wellbeing.

Steps were not in place to ensure that the deployment of staff was appropriate to support people safely.

The management of medicines ensured that people received their prescribed medication.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There was a lack of evidence to show that staff had received a thorough induction or received regular formal supervision.

Although staff had received training updates, this was not always demonstrated in their practice and approach through the care and support people received.

Monitoring and management of people's nutritional and hydration needs were poor and we could not be assured that people received a satisfactory diet or fluid intake.

Staff had a good knowledge and understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Where people lacked capacity, decisions had been made in their best interests.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Although some people stated that staff treated them with care and kindness, care provided was often task focused and people said that staff did not sit and talk with them for any meaningful

period of time.

Staff communication with some people was poor.

People's end of life wishes and the care to be provided was not recorded.

Is the service responsive?

Inadequate

The service was not responsive.

People's care plans were not regularly reviewed or reassessed. Not all people's care records were sufficiently detailed or accurate.

People were not always engaged in meaningful activities and supported to pursue pastimes that interested them, particularly for people living with dementia.

Effective arrangements were not in place for the management of complaints.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of managerial oversight of the service as a whole.

People were put at risk because systems for monitoring quality were not effective. The systems had also not identified the areas of concern that we had found.

The culture of the service was not centred on the person but was more around the tasks that the staff had to achieve each day. This approach did not support people's individual needs.

Willows Lodge Care Home

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 is 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 rating for the service under the Care Act 2014.

This inspection took place on 12 January 2016, 13 January 2016 and 19 January 2016 and was unannounced. The inspection team consisted of two inspectors on 12 January 2016 and 13 January 2016. On 19 January 2016 one inspector visited the service between 21:00 and 23:40. On 12 January 2016 the inspectors were accompanied by an expert by experience. An expert by experience is a person who has personal experience of caring for older people and people living with dementia.

We reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

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 spoke with 20 people who used the service, six relatives, one independent advocate, the clinical lead, two registered nurses, 19 members of care staff (including unit team leaders), the registered provider and the registered manager.

We reviewed 12 people's care plans and care records. We looked at the service's staff support records for seven members of staff. We also looked at the service's arrangements for the management of medicines, complaints and compliments information and quality monitoring and audit information.

Inadequate

Is the service safe?

Our findings

People were at risk because the provider had not always taken appropriate steps to ensure that people were protected from abuse. Robust procedures did not ensure that the provider, management team or staff understood their individual responsibilities so as to ensure that action was taken as soon as they suspected abuse or the risk of abuse in line with local safeguarding procedures.

We found no evidence to show that three incidents had been considered and/or reported under safeguarding procedures to the Local Authority to prevent reoccurrence and safeguard people from further potential abuse. For example, a sheet of A4 paper folded in half was noted within the service's complaints file. On one side this detailed that restraint had been used to restrict and impede one person's movement whilst they remained in bed. On the other side of the sheet of A4 paper this recorded that one person who used the service had become distressed as they had been asked by night staff not to use their call alarm facility so as to summon assistance. It further recorded that this had resulted in the person taking the decision to get in and out of bed without staff support and to sleep in a chair. Both incidents were discussed with the provider and registered manager and they told us that they had been unaware of either incident. In addition, a record was maintained detailing an incident whereby an invasive procedure by a healthcare professional was undertaken. Records showed that this had occurred as a member of care staff from the service had misdirected the healthcare professional to the wrong person using the service. Records showed that the provider and registered manager were aware of the latter however, no consideration had been given to raise this with the Local Authority. As a result of our concerns the above information was provided to the Local Authority safeguarding team by the Care Quality Commission.

Although staff were able to demonstrate an understanding and awareness of the different types of abuse, the staff training matrix provided by the registered manager at the time of the inspection showed that over a third of staff employed at the service did not have updated safeguarding training.

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

Although intuitively staff knew the people they supported and some risks were identified and recorded relating to people's health and wellbeing, for example, the risk of poor nutrition, poor mobility and the risk of developing pressure ulcers, this was inconsistently applied. Additionally where risks were identified, suitable control measures were not put in place to mitigate the risk or potential risk of harm for people using the service.

For example, one person living with dementia on Poppy Unit was observed on 12 and 13 January 2016 on three occasions to climb over the top of their bedrails. The person's daily care records over a twelve day period showed that they regularly climbed over their bedrails; and on some days staff had noted that this was a frequent occurrence. Although the person had been assessed in December 2015 as to their suitability to have bedrails fitted and in place, the assessment had not been updated to reflect a change in the person's circumstances. Although a crash mat had been placed on the floor adjacent to the person's bed,

the bedrails had not been lowered to their lowest position and steps had not been taken to consider a reassessment of their needs or to remove the bedrails. We discussed this with the clinical lead and they told us that they had instructed staff the week previous to lower the person's bedrails. However, staff had not followed these instructions and the clinical lead had failed to follow-up their instruction until our intervention. We were seriously concerned that risks relating to this situation were not being monitored or effectively managed so as to ensure the person's safety and meant that the person remained at risk.

Additionally we found that adequate control measures were not put in place to mitigate the risk or potential risk of harm for another person. For example, one person was observed to eat their lunchtime meal in the dining room whilst in a horizontal position with their plate of food balanced on their stomach. Despite this potentially serious situation whereby the person was at risk of choking, no staff attempted to alter the person's bodily position so as to increase their comfort, promote oxygenation and decrease their risk of choking. This meant that staff were unaware of the potential risks posed and the increased risk of choking to the person they supported. On review of their nutritional care plan, this recorded that the person required encouragement to eat and drink, coughed from time to time whilst eating and when in their chair needed to be repositioned in 'fowlers' position every time so as to prevent coughing and choking. Fowlers position is a standard position used to promote oxygenation and to increase a person's comfort and there are four different positions that can be used for the person to be seated comfortably and according to their needs. No specific further information was recorded to explain this and what this meant for the individual. We discussed this with the registered manager and the clinical lead and both were unaware as to the term 'fowlers' and what this meant.

Some people were assessed as at high risk of developing pressure ulcers. We checked the setting of pressure relieving mattresses that were in place to help prevent pressure ulcers developing or deteriorating further and found that not all equipment was correctly set in relation to the person's weight. For example, for one person the setting was observed to be set on '8' [140KG] and yet their actual weight on 2 January 2016 was 65.75KG and should have been on setting '3' or '4'. This meant that the amount of support the person received through their pressure mattress was incorrect and would not aid pressure ulcers from developing or deteriorating further. We made the provider and registered manager aware of our findings on 13 January 2016. However, when we returned to the service on 19 January 2016 and inspected the pressure relieving equipment for the same person, we found that the setting remained inaccurate in relation to their weight. The setting was observed to be set on '5' [96KG] and yet the person's weight as of 18 January 2016 was recorded as 68.1KG. We discussed this with the registered nurse on duty and instead of altering the setting with immediate effect, a note was written in the communication book for day staff to action. This showed that actions to mitigate any risks to the person had not been taken seriously or addressed.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Comments about staffing levels from people using the service and those acting on their behalf were generally negative as they did not think that there were sufficient numbers of staff available to meet their needs, particularly at weekends. Two people who used the service told us when asked if there were enough staff, "Sometimes yes and sometimes no. If one is sick it's hard we need more staff. If they [staff] are short upstairs they may take one [staff] from here [Rose Unit]" and, "No I don't, not compared with what they [staff] have to do. I don't always get a bath when I want and agency staff are next to useless." Another person told us, that staff regularly stated in front of them that the service was short staffed. They confirmed that at times the lack of staff available meant they did not always receive personal care when they asked for assistance. They told us, "You don't always know when you will get the care. Asking is one thing and actually getting the care is another." Relative's comments included, "There are not enough staff, definitely not,

especially at weekends," "Sometimes you cannot find any staff" and, "It's [staffing levels] OK during the week but not at weekends."

Our observations on the first two days of inspection showed that staff did not always have enough time to spend with people to meet their needs. The care and support provided was routine and task orientated and this was evident from our observations. The deployment of staff was not always suitable to meet people's needs. For example, on Buttercup Unit on the first day of inspection we noted that the main communal lounge was left without staff support for a continuous period of 25 minutes. Although six people were seated within the communal lounge, one person had been assessed as 'high risk' of falls and required close observation. We also noted on the first day of inspection, particularly on Buttercup Unit, the majority of people remained in bed. Out of 24 people residing on the unit, only six people were supported by staff to get up. Records showed that there was no rationale recorded for this decision and staff were unable to provide further explanation. We discussed this with the registered manager and clinical lead. Both the registered manager and clinical lead advised that there was no obvious reason why people should not have the opportunity to get up out of bed, whether it is was for a short period of time, for example, one or two hours or longer. On the second day of inspection we noted that a lot of people had been supported to get out of bed for the day.

Staff's comments relating to staffing levels were variable. Staff told us that staffing levels were not always maintained. The staff rosters showed that staffing levels as told to us by the registered manager had not always been maintained. Staff confirmed that there were occasions whereby staff could be deployed to work within another unit; however that could then leave the other unit short staffed.

The registered manager was unable to confirm how staffing levels at the service were calculated so as to determine the number of staff required. We discussed this with the registered manager and they confirmed that the dependency levels for each person were assessed and recorded each month. However, following further discussion with the provider we found that there was no systematic approach to analyse the results so as to determine the number of staff required, to review the service's staffing levels and to ensure that the deployment of staff met people's changing needs and circumstances.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us that they received their medication as they should and at the times they needed them. The arrangements for the management of medicines were safe. Medicines were stored safely for the protection of people who used the service. There were arrangements in place to record when medicines, such as, tablets and liquid medication were received into the service, given to people and disposed of. We looked at the records for 15 of the 55 people who used the service on Buttercup and Poppy Units. These were in good order, provided an account of medicines used and demonstrated that people were given their medicines as prescribed. Observation of the medication round showed this was completed with due regard to people's dignity and personal choice. Although the above was positive, improvements were required as there was no evidence to show that people's topical creams were administered as prescribed. This meant that there was no confirmation to show that staff were applying the topical cream appropriately. The registered nurse and unit team leader for the respective units confirmed that no 'topical cream charts' were available. We discussed this with the registered manager and the clinical lead and both advised that it was their expectation that appropriate documentation should have been completed.

Prior to our inspection concerns were raised that staff did not have sufficient cleaning equipment. We discussed this with the housekeeping staff and they told us that there were no problems with the level of

cleaning supplies made available to them. However, this was in contrast to what staff told us. They advised that there were times when they had to go to the nearest superstore and purchase hand wipes and disposable gloves, particularly at the weekend.

We looked around the premises and found that all areas of the home environment were clean and there were no unpleasant odours. We found that there were sufficient supplies of personal protective equipment for staff usage. These were for single use only and discarded after personal care with a person who used the service had been delivered so as to prevent the transfer of infection from one person to another. Records showed that infection prevention and control audits had been completed. The audits indicated that there was a good level of compliance. Where issues had been highlighted as requiring corrective action an action plan had been completed. We found that daily cleaning schedules were in place for all areas of the home environment. Records showed that these were completed each day by the service's house-keeping staff. We found that the laundry facilities were sited so that soiled clothing and infected linen were not carried through areas where food was stored and prepared and did not infringe on people's rooms or communal areas. We found that there were suitable arrangements in place so that dirty laundry was handled with care and reduced the potential spread of infection.

Suitable arrangements were in place to ensure that the right staff were employed at the service. Staff recruitment records for staff appointed since July 2015 showed that the provider had operated a thorough recruitment procedure in line with their policy and procedure. This showed that staff employed had had the appropriate checks to ensure that they were suitable to work with people.

Requires Improvement

Is the service effective?

Our findings

Staff told us they received an induction when first newly employed at the service. This included an 'orientation' induction of the premises and was generally completed over one day. The registered manager was aware of the new Skills for Care 'Care Certificate' and how this should be applied. However, despite several requests to see an induction for a newly employed member of staff who had completed more than the basic induction, this was not forthcoming and we were told that the inductions requested had been archived. In addition, although we asked on a number of occasions to view induction records for agency staff utilised within the service over the past four weeks, these could not be located or provided. On 19 January 2016 a blank agency induction form was noted with the instruction, 'This must be completed with the night nurse tonight with this agency staff member.' The agency member of staff confirmed that this was their fourth shift at the service and although initially shown round the premises, could not remember if a formal induction had been completed or a record maintained.

Staff told us that they were well supported by the registered manager. One staff member told us, "I feel well supported by the registered manager who is very understanding. For example, they told us that in addition to working at Willows Lodge Care Home, they provided caring duties for aging relatives. They told us that the management team had been flexible to accommodate this. Another staff member stated, "The registered manager is very supportive and is always there if you need them." The supervision matrix showed that although there was a supervision and appraisal system in place, this was not happening in line with the provider's own policy and procedure which stated, 'All staff receive formal supervision at least 6 times a year.' Not all staff were able to tell us when they had last received supervision and some staff told us that they had not received regular supervision since July 2015. This meant that although staff felt supported they might not always have a structured opportunity to discuss their practice and development to ensure that they continued to deliver care effectively to people. Records viewed confirmed this.

Staff told us that they received regular training opportunities in a range of subjects and this provided them with the skills and knowledge to undertake their role and responsibilities and to meet people's needs to an appropriate standard. Although the registered manager provided us with a copy of the service's staff training matrix and confirmed this was up to date, this showed that all staff's' mandatory updated training in 11 key topics was completed on 17 and 18 December 2015. We were not reassured as to how all staff could have received comprehensive training in all of these topics in a limited two day period or that the quality of the training provided was suitable. In addition to this the training matrix recorded no evidence of updated training for 25 members of staff and not all staff detailed on the staff roster was included on the matrix. For example, the staff rosters for Poppy Unit for the period 14 December 2015 to 10 January 2016 inclusive showed that four members of staff rostered were not detailed on the staff training matrix and there was no evidence of training undertaken for seven members of staff.
Gaps in staffs' training and where staff had received a lot of training in a relatively short period of time, our observations showed that people's needs were not consistently met by a staff team who had the right competencies, knowledge and skills to meet people's diverse care and support needs. Evidence provided to us at the time of the inspection showed that not all staff were suitably trained. This was demonstrated in staffs' care practices and attitude towards the support individual people received. For example, if staff had

received appropriate training relating to nutrition and hydration for older people and pressure ulcer management training, staff would have been able to recognise the importance of repositioning people at regular intervals so as to maintain good skin integrity and the significance of why people should receive appropriate nutrition and hydration where they were at risk.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our observations showed that the dining experience for people on Rose Unit was positive. People told us that the meals provided were nice and they were given sufficient choice of meals and alternatives were readily available. People received their meal in a timely manner and the meals provided were sufficient in quantity and looked appetising. None of the people on Rose Unit required help by staff to support them to eat and drink. This showed that people were enabled and empowered to maintain their independence and skills.

However, this was in contrast to our observations of the dining experience for people living with dementia on Poppy Unit and people with complex nursing needs on Buttercup Unit. Our observations showed that consideration by staff was not always well-thought-out to ensure that eating and drinking was an important part of people's daily life, was a positive experience for people or treated as a social occasion. People were not always given a choice of drinks and drinks were not readily available to people with the lunchtime meal. Some staff failed to provide sufficient information, explanation or reminder to people about the actual meals provided, for example, people were not told what food items were on their plate. People were not supported to wash their hands or offered wipes so as to ensure that their hands were clean prior to eating. The dining tables were not properly laid, such as; there was no cutlery, serviettes or condiments readily available.

People were not always supported to eat and drink enough. We found that people who were cared for in bed were not always encouraged or given the choice or opportunity to get out of bed for lunch. The rationale for why people remained in bed throughout the day was not recorded within their care file.

The nutritional needs of people were identified and where people who used the service were considered to be at nutritional risk, we found that referrals to a healthcare professional such as GP, Speech and Language Therapist and/or dietician had not always been made. Where instructions recorded that people should be weighed at regular intervals, for example, weekly or monthly, this had not always happened or been followed. This meant that staff could not be sure that people were maintaining their weight or were not losing weight. In addition, we found that a record of the meals provided and fluids taken had not always been maintained in sufficient detail to establish if people's dietary needs were being monitored, managed or encouraged where this was required. This was of specific concern for those people who were supported in bed due to their ill health. There were no clear records of the nutritional care and support these people were receiving and staff were unable to confirm what nutritional care they had received during the day as the records were poorly completed. Where people refused a meal, there was limited evidence to show that alternatives to the menu were routinely offered and/or provided by staff. For example, the records for one person newly admitted to the service showed on 17, 18 and 19 January 2016 that they had refused and/or declined all food. During this same three day period the person had only drunk a total of 1050 millilitres and five sips of fluid. No other information was recorded detailing other food and drink presented.

This is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that their healthcare needs were well managed. People's care records showed that in general their healthcare needs were recorded and this included evidence of staff interventions and the outcomes of healthcare appointments. Each person was noted to have access to local healthcare services and healthcare professionals so as to maintain their health and wellbeing, for example, to attend hospital appointments and to see their GP. However, for one person we noted that no action had been taken to contact a healthcare professional following the person declining to eat for three days. We discussed this with the provider and an assurance was given that action would be taken to follow this up. All but one relative confirmed that they were kept informed of their member of family's healthcare needs and the outcome of healthcare appointments. One relative told us, "The staff are very good at keeping me informed." Another relative told us when asked if healthcare professionals were contacted for their member of family, "Yes, and they called me when my relative was taken to hospital."

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. 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.

Staff told us that they had received Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Staff were able to demonstrate a basic understanding of MCA and DoLS, how people's ability to make informed decisions can change and fluctuate from time to time and when these should be applied. Records showed that where appropriate people who used the service had had their capacity to make decisions assessed. This meant that people's ability to make some decisions, or the decisions that they may need help with and the reason as to why it was in the person's best interests had been recorded. Appropriate Deprivation of Liberty applications had been made to the Local Authority for their consideration and authorisation.

We found that the arrangements for the administration of covert medication for one person was in accordance with the Mental Capacity Act (MCA) 2005. 'Covert' refers to where medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in drink.

Requires Improvement

Is the service caring?

Our findings

Overall people and their relatives told us that staff cared for people in a caring and compassionate way. One person told us, "[Staff] very caring, I'm quite happy here." Another person told us, "Oh yes the staff are very caring. I couldn't wish for better staff. No complaints at all. I couldn't get on without them." One relative told us, "Yes, especially two or three of the staff. Staff are always telling me how my relative is. Staff genuinely care about my relative and spend time with them." However, our findings in terms of how staff were supported to ensure people's well-being and all support functions including care records and management support did not concur with people's comments about a caring service.

Where negative comments were made these generally related to night staff. People told us that they found some night staff's command of the English language and pronunciation difficult to understand. In addition, some people told us that their experience of care provided by some members of night staff required improvement. People told us that some staff could be rough, particularly when providing intimate personal care. One person told us, "The day staff are OK but some night staff can be rough when supporting you."

People's preferences and choices for their end of life care were not clearly recorded, communicated and kept under review. The registered manager confirmed that there were 10 out of 21 people identified as nearing the end of their life. We found that the needs of people approaching the end of their life and associated records relating to their end of life care needs were either not up-to-date or not recorded. For example, the care plans provided little or no information detailing people's pain management arrangements and the care to be provided so as to provide comfort to the person. No information was recorded to identify who may have a few months, weeks or days to live; in order to aid care planning arrangements and discussions with the person and those acting on their behalf. This meant that people's 'end of life' wishes were not recorded in line with new guidelines issued by the National Institute for Health and Care Excellence [NICE]. The latter places emphasis for a more individualised approach to 'end of life' care.

No information explaining what treatment should be provided for people's health if they were no longer able to make decisions for themselves was recorded (Advanced Directive). This meant that we could not evidence that people and those acting on their behalf were involved in the assessment and planning for their end of life care or supported to make choices and decisions about their preferred options.

Additionally, the records did not always suggest that the care and support provided by staff was proactive or demonstrated consistent end of life care. For example, the care plans for several people recorded that they were at risk of developing pressure ulcers. We could not be assured that people had been repositioned so as to prevent the development of pressure ulcers or further deterioration as our observations and records to evidence this had not been consistently completed to show staff's interventions. For example, our observations and the repositioning records for one person showed that they were not repositioned frequently and could spend several hours lying in the same position despite instructions on their care plan detailing that they were to be repositioned at regular intervals. Over a two day period the records showed and our observations suggested that the person had remained in the same position for over 24 hours.

Another person's records showed that despite having a pressure ulcer, over a five day period the person did not have their body repositioned after 16.05 and 18.30 respectively each day. These were not isolated cases. This meant that we could not be assured that people were receiving suitable care and support from staff that met their individual care needs or were being repositioned as part of a fundamental component of pressure ulcer prevention and treatment.

Although the above was noted, the registered manager confirmed that the involvement of appropriate healthcare professionals, such as, District Nurse services and the local Palliative Care and End of Life Teams were available as and when required and following discussions with people's GP.

We observed that staff interactions with people were variable with some interactions positive and others routine and task focused, for example, some staff only spoke with people or interacted with them when providing personal care or assisting them to eat and drink. Our observations indicated that not all staff showed concern for people's wellbeing in a caring and meaningful way or responded to people's individual needs quickly enough. One person told us that there were occasions when their call alarm facility was ignored by staff and that the level of care they received often depended on which staff were on duty. We also observed this during our inspection, for example, we advised the registered nurse on duty on 19 January 2016 that one person required assistance with their personal care so that they could retire to bed. The registered nurse advised that they were assisting another person but would attend to the person's needs in approximately 10-15 minutes. After 20 minutes we spoke with the registered nurse again and enquired as to when the support would be provided. They confirmed that they were now assisting another person and would not be able to provide support to the person for up to a further 30 minutes. We discussed this with the person and they told us, "Nobody cares whether I'm tired or not. Sometimes I can be sat here till gone midnight." They told us that they did not think they mattered. This showed that staff routines and preferences took priority over other people's needs and demonstrated that some staff had little understanding of the impact of this approach on individual people's sense of self-worth and wellbeing.

Staff's communication with people living at the service was variable, for example, some staff were seen to kneel down beside the person to talk to them or to sit next to them and staff provided clear explanations to people about the care and support to be provided in an appropriate way. Other members of staff were observed to have difficulty communicating with people and understanding their needs, such as, not enabling people the opportunity to make choices or providing clear explanations to a person prior to undertaking a specific task. Where interactions were positive, staff rapport with people living at the service was observed to be friendly and cheerful. This was clearly enjoyed by people and there was positive chit-chat between both parties.
This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although staff understood people's care needs and the things that were important to them in their lives, for example, members of their family, key events, hobbies and personal interests, further improvements were required to enable people to make day-to-day choices, informed choices and to promote their independence where appropriate and according to their abilities.

The majority of people told us that they were treated with respect and dignity. Our observations showed that staff respected people's privacy and dignity, such as, we saw that staff knocked on people's doors before entering and staff were observed to use the term of address favoured by the individual. In addition, we saw that people were supported to wear clothes they liked and that suited their individual needs. However, we advised the provider and registered manager at the time of the inspection that one person who predominately remained in bed throughout the day on Buttercup Unit was frequently observed whilst laid in

bed to wear nothing but a 't' shirt and an incontinence pad. This did little to preserve the person's dignity or modesty and staff appeared unaware of this.

The registered manager told us that where some people did not have family or friends to support them, arrangements could be made for them to receive support from a local advocacy service. The registered manager confirmed that one person using the service had an advocate. Information about local advocacy services and other useful information for people and those acting on their behalf to access were displayed on a noticeboard in the main foyer. People were supported to maintain contact with family and friends and relatives told us that they were always welcomed and that there were no restrictions on visiting times.

Inadequate

Is the service responsive?

Our findings

Arrangements were in place to assess the needs of people prior to admission. This ensured that the service was able to meet the person's needs. However limited evidence was available to show that where appropriate this had been conducted with the person or those acting on their behalf.

We found inconsistencies across the service in the quality of the information included in people's care records. Some provided sufficient detail to give staff the information they needed to provide personalised care and support that was consistent and responsive to their individual needs. However, others were not fully reflective or accurate of people's care needs. For example, one person was recorded as having a grade 4 pressure ulcer. Despite this potentially serious medical condition, no care plan was in place detailing the care and treatment to be provided by staff so as to protect and maintain the person's skin integrity from further breakdown. For others, we found that no comprehensive preventative care plans were in place where people were identified as being at high risk of developing pressure ulcers.

In addition, our observations on 12 and 13 January 2016 showed that two people required the use of oxygen so as to help them to breathe more easily. No care plan was recorded for one person. We discussed this with the provider and registered manager at the time. However, when we returned to Willows Lodge Care Home on 19 January 2016 we found that another person who was newly admitted to the service after the 13 January 2016 and required the use of oxygen, did not have a care plan in place. No information was recorded detailing the correct flow rate of oxygen to be delivered to the person over a 24 hour period or the equipment in situ, such as, mask or nasal cannula. In addition to the above no care plan documentation was evident for three people. For example, on the first day of inspection one person had been without a care plan for a period of 22 days. We discussed this with the clinical lead nurse and unit team leader on the designated unit and they confirmed that these were not available as they had not been written up. This meant that care plans in place did not always reflect people's current care needs or the complete absence of other care plans meant that staff were not provided with sufficient information to deliver care and support to an appropriate standard.

Staff told us that there were some people who could become anxious or distressed. Improvements were required to ensure that the care plans for these people considered the reasons for people becoming anxious and the steps staff should take to comfort and reassure them. Guidance and directions on the best ways to support the person required reviewing so that staff had the information required to provide appropriate care. Although specific incidents had been recorded where people could become anxious and distressed, little quantitative information was recorded detailing staff's interventions and outcomes.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a complaints process and procedure in place that identified how people could raise concerns and what would happen. People living at the service and those acting on their behalf confirmed that they would feel comfortable and able to make a complaint if the need arose. In some cases people told

us that they had made a complaint to the management team. However, one person told us that they had not made a formal complaint as their relative did not want them to raise a complaint for fear of repercussions. Another person told us, "There is no point saying anything here because if you say anything there are repercussions from staff." When questioned further they told us that if they complained or made a fuss, care provided by staff could be delayed for several hours.

Although a record was maintained detailing the specific nature of each complaint, there was not always evidence of the investigation, action taken and proof of how decisions and conclusions had been reached. In addition, the registered manager was unable to provide any evidence to show that all complaints received had been dealt with or responded to in line with the provider's complaints procedure. For example, one complaint record referred to concerns relating to missed medical appointments. The provider's complaints form had not been completed and information relating to the concerns was recorded on a sheet of paper. Statements from three members of staff were evident but not dated. No information was recorded to confirm that the complainant had had their concerns acknowledged or received a response detailing the outcome and conclusion of their complaint. Although the registered provider confirmed that they were aware of the concerns raised and that the complaint had been dealt with, evidence of the investigation, action taken and outcome were not available to support what they told us.

This is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were needed in the way the service and staff supported people to lead meaningful lives. The registered manager confirmed that two members of staff were responsible for supporting people to access meaningful pastimes. They told us that they did their best to support people to take part in activities of their choice and personal preference.

Not all people using the service or people's relatives were complimentary about social activities provided at the service. People told us that the opportunities provided to engage in meaningful activities was limited and some people told us that they could get bored sometimes. People and relatives told us that they did not think that there were enough things going on. One person told us, "I watch TV. I don't like sitting in the lounge as there is nothing going on." Another person told us that as a result of their poor mobility little provision was made for them to participate in meaningful activities. They told us, "I used to do activities. I got out in the garden last year." One relative told us, "They have some singing and bingo but my relative has never been on an outing."

On the first day of inspection no staff responsible for supporting people to access social activities were available. Some staff did undertake ball games with people on Poppy Unit and on Buttercup Unit a DVD film was being played on the television. No other opportunities for people were undertaken on the units to engage people with social activities. On the second day of inspection ball games were played again on Poppy Unit and one person had a manicure. We found little evidence that activities provided were linked to people's past hobbies or interests and involved 'everyday tasks' such as assisting staff to lay the table, help with laundry, dusting or gardening. In addition, there was no indication that reminiscence, including memory boxes, objects of reference and life story work was used to help trigger memories or enable people the opportunity to independently entertain themselves. This meant that people were not encouraged to keep active or to stay involved in their surroundings.

Inadequate

Is the service well-led?

Our findings

The service was newly registered on 31 July 2015. Although the service had a registered manager in post, the registered manager was absent from the service between 23 July 2015 and 20 October 2015 as a result of unforeseen circumstances. The provider notified the Care Quality Commission of the above and confirmed that the service in the interim would be managed by one of the organisations two area managers. The area manager commenced day-to-day management of the service on 27 July 2015, four days a week until 14 November 2015. To support the registered manager a clinical lead nurse commenced employment at the service in December 2015.

It was apparent at this inspection that the quality of the leadership within the service was weak. The registered manager and other senior members of staff were not effective role models and did not lead by example. Although the registered manager stated that they were available to staff for guidance and support, the registered manager primarily sat in their office and spent little time observing what was happening within the service.

We were advised by the provider and registered manager that a system was in place to monitor the quality of the service through the completion of a number of audits. The provider confirmed that it was their expectation that the audits were completed at regular monthly intervals. In addition to this the provider confirmed that an internal audit by the area manager was required to be completed each month so as to ensure a review of all areas of its quality assurance systems were completed and any actions highlighted addressed. We found that between August 2015 and December 2015 only one audit had been completed by the area manager. This highlighted that all areas viewed were non-compliant. The area manager recorded that action was required and the target completion date was 'Immediate.' No evidence was available to show that action had been taken by the provider to address the issues raised or to follow these up.

Although these systems were in place, they were ineffectual as they had not been completed each month and had not highlighted the areas of concern we had identified at this inspection. In addition systems in place did not ensure people's safety or mitigate risks relating to their health, safety and welfare of people using the service. Where strategies were in place it was evident that these were either not working or not being followed by staff. There was no evidence to show that the providers own quality assurance systems effectively analysed and evaluated information so as to identify where quality or safety for people using the service was compromised, to drive improvement and to respond appropriately.

The lack of management oversight had led to safeguarding concerns and people's complaints not being dealt with as required, this placed people at potential risk of harm and the provider was unable to show how they had listened to people and used their concerns to improve the quality of the service. Further lack of monitoring and oversight from the management team meant that records relating to staff employed and people using the service were not properly maintained. Quality assurance systems had not picked up that there were gaps in staff's training or that some staff had not received mandatory training. Systems were not in place to monitor the quality of staff inductions or to ensure that staff received regular opportunities for formal supervision. Our observations showed that responsibility by the nurses and unit team leaders for leading each shift was inconsistent and staff were not being supervised properly. The provider did not have an effective system in place to review staffing levels so as to determine that the deployment of staff was suitable to meet people's needs. This lack of ability to assess the suitability and ongoing skills levels of staff

meant that the management of the service could not be assured that people were being cared for safely and their needs met as required.
In general it was clear from our discussions with the registered manager and clinical lead nurse and from our observations that they had an understanding of their key role and areas of responsibility but had little perception and awareness as to what was required of them to ensure the quality running of the service and the delivery of good care for people.
It was apparent from our inspection that the absence of robust quality monitoring was a contributory factor to the failure of the provider to recognise breaches or any risk of breaches with regulatory requirements sooner. The provider was unable to demonstrate how they intended to comply with the regulations as set out in the Health and Social Care Act 2008. This showed that there was a lack of provider and managerial awareness and oversight of the service as a whole as to where improvements were required.
Staff meetings were held at regular intervals so as to give staff the opportunity to express their views and opinions on the day-to-day running and quality of the service. Minutes of all meetings undertaken to date were not readily available to confirm the matters raised and discussed or the actions highlighted. In addition, there were no action plans completed to evidence how issues raised were to be addressed, the dates to be achieved and if these had been resolved or remained outstanding. Records showed that since the service had been newly registered there had been one relatives meeting held in November 2015. Although an account of the meeting was recorded, this underlined areas for improvement. For example the minutes recorded, 'Many [relatives] raised the issue of night staffs attitude and being very unapproachable and rude.' They also detailed that some people who used the service felt that breakfast could be rushed. No evidence was available of the actions taken to address people's comments.
This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relative's comments relating to the management of the service were mostly complimentary. One relative told us, "Very good manager. They are approachable. Feel they know my relative." Another relative told us, "The manager is very amenable." One person who used the service told us, "The manager's alright. I speak to them every day." Another person told us, "They're alright. I don't see much of them." Staff were very complimentary about the registered manager and stated that they were supportive. Staff were positive about their role and we had comments such as, "I love my job and get a real buzz out of it" and, "I love it here."

The provider and registered manager confirmed that the views of people using the service and those acting on their behalf had yet to be completed. The registered provider told us that this would be initiated in February 2016 and a report of the findings completed April or May 2016.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care We found that the registered provider had not ensured that people's assessments included all of their needs that they were reviewed regularly and an accurate record of care and treatment provided remained accurate. The provider had not protected people against the risks of receiving care and treatment that was inappropriate and did not meet their needs. This was in breach of Regulation 9(1)(a)(b) and 9(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Notice of Decision to impose conditions on the provider to restrict admissions at Willows Lodge Care Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment We found that the registered provider had not ensured that people were protected from abuse. Systems and processes were not established and operated effectively to investigate safeguarding concerns. This was in breach of Regulation 13(1)(2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Notice of Decision to impose conditions on the provider to restrict admissions at Willows Lodge Care Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs We found that the registered provider had not

Diagnostic and screening procedures Treatment of disease, disorder or injury	protected people against the risks of receiving inadequate nutrition and hydration. This was in breach of Regulation 14(1), 14(2)(b) and 14(4)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Notice of Decision to impose conditions on the provider to restrict admissions at Willows Lodge Care Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints We found that the registered provider and manager did not have effective systems in place to deal with comments and complaints. This referred specifically to not considering fully or responding appropriately to comments and complaints.

The enforcement action we took:

Notice of Decision to impose conditions on the provider to restrict admissions at Willows Lodge Care Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance We found that the registered provider and manager had not protected people against the risks of inappropriate or unsafe care as the arrangements to assess and monitor the quality of the service provided was ineffective. This was in breach of Regulation 17(1)(2)(a)(b)(c) and 17(2)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Notice of Decision to impose conditions on the provider to restrict admissions at Willows Lodge Care Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing We found that the registered provider had not ensured that there were sufficient numbers of staff deployed so as to make sure that they can meet people's care and treatment needs. Additionally, the provider had not ensured that staffs training, learning and development needs had supported them to fulfil the requirements of their role to meet people's needs.This was in breach of

Regulation 18(1) and 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Notice of Decision to impose conditions on the provider to restrict admissions at Willows Lodge Care Home.