Cotswold Spa Retirement Hotels Limited

Willow Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Willow Court Care Home is a residential care home providing nursing and personal care to 35 older people at the time of the inspection, including some people living with a dementia type condition. The service can support up to 48 people. Care is provided over two floors.

People's experience of using this service and what we found
There were not enough staff to support people. Staff told us they did not always have time to complete all of their tasks. People and relatives told us staff were sometimes very rushed. In response, shortly after the inspection, the registered manager told us staffing levels had been increased. Accidents and incidents had been reviewed, but the level of detail within investigations varied. Medicines were well managed and the home was clean.

The provider's quality monitoring system had not addressed the issues we had found. The provider's tools to assess staffing needs did not include some key performance information. People, relatives and staff were given opportunities to share their views on the service. We were told the registered manager was approachable and hard working, however, they did not have a deputy manager or permanent nursing staff to support with leading the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection
The last rating for this service was Good (published 21 March 2018).

Why we inspected
The inspection was prompted in part by concerns we received about staffing levels. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-Led only

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.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-Led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Willow Court Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified one breach in relation to staffing levels at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from 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.

Willow Court Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. 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.

Inspection team
The inspection team was made up of an inspector and an assistant inspector.

Service and service type
Willow Court Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 from the provider since the last inspection, such as information about any serious injuries or deaths.

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 sought feedback from the local authority and Healthwatch about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and

social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service and four relatives about their experience of the service. Some people who used the service could not verbally communicate their experience of the care they received. 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 the registered manger, the provider's regional manager, a nurse, five care staff, one member of the maintenance team and the cook. We reviewed a range of records. These included four people's care records and medicines records. We looked at records relating to the management of the service and a variety of policies and procedures.

After the inspection
We asked the provider to send us some additional information so we could validate the evidence we found.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as 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.

Staffing and recruitment

- There was not always enough staff to safely support people. The provider's staffing tool assessed the numbers of staff needed based on people's needs. However, the home was usually staffed with two fewer staff than this assessment tool recommended.
- People, relatives and staff raised concerns about the number of staff on duty. One staff member said, "Staffing levels aren't good. We aren't able to give people enough attention, especially at mealtimes. We can't rush people, but we know there are other people who might need to be changed. It can be quite stressful."
- The registered manager and provider had not always taken action to make sure there were enough staff.

The service was not always adequately staffed. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. The registered manager told us they were already in the process of reviewing staffing levels. Shortly after the inspection, they told us an additional member of staff would be scheduled to work each day.

- Safe recruitment practices were followed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Staff did not always have enough information to best support people's behavioural needs. Care records were not always specific about how staff should respond to people if they were anxious.
- Investigations into accidents and incidents varied in quality. One accident had not been investigated in enough detail to determine the cause. Following our inspection the registered manager carried out an additional investigation.
- Risks to people had been assessed and plans put in place to keep people safe.

Systems and processes to safeguard people from the risk of abuse

- People and relatives told us the home was safe.
- Systems were in place to minimise the risk of abuse.

Using medicines safely

- Medicines were managed safely.

● People received their medicines as prescribed. These were administered by trained staff.
● Staff did not always have enough information about 'as required' medicines. It was not always clear when this should be administered. The registered manager arranged for care records to be re-written to include these details.

Preventing and controlling infection
● The home was clean.
● Staff followed guidance to minimise the risks of infection.

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

- The provider's monitoring systems and processes had not addressed shortfalls in the delivery of the service. The registered manager and regional manager regularly carried out checks and completed reports to check on the quality of the service. The provider was in the process of reviewing staffing levels within the home, but these systems had not ensured there were always enough staff to safely support people.
- Risks to people from staff shortages had not been mitigated. The provider's staffing risk assessment, used when staffing levels were lower than the dependency assessments guidelines, was not robust. Key measures such as call bell response times and feedback from people and staff were not incorporated into the risk assessment.
- Key leadership roles within the home were vacant. At the time of our inspection, the roles of deputy manager and permanent nurses were unfilled. Nursing shifts were carried out by agency staff. The regional manager told us new staff were due to start in these positions to provide additional leadership support.
- The registered manager had notified CQC of significant events at the home in line with legal requirements.

Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider monitored safeguarding incidents and complaints. These were analysed to identify any lessons learned so action could be taken to reduce the risk of any reoccurrence.
- The registered manager understood their duty of candour responsibilities.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Staff and relatives told us the registered manager was approachable and hard working.
- People, relatives and staff could share their feedback and views on the service. Meetings were held regularly. Surveys about the service could be completed at any time on an electronic tablet.

Working in partnership with others

- Staff worked with health and social care professionals so people received joined up care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient numbers of staff available to meet people's needs. Regulation 18(1)